

Medical physical examination in connection with torture

Section III*

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Neurological

Acute central nerves neurological problems are associated with severe beatings to the head. In 200 torture victims 58% had received severe beating to the head and 1/4 of those consequently lost consciousness¹. Headache was the most frequently reported symptom present in more than 50% of the examined persons. A significant correlation between severe beating on the head and headache was found. Likewise there was a significant association to the symptom vertigo present in 20% of the persons.

Violent shaking may produce cerebral injuries identical to those seen in the shaken baby syndrome: cerebral oedema, subdural haematoma and retinal haemorrhages. The first fatal instance of “shaken adult syndrome” was reported by Pounder and Path³².

Acute peripheral nerves symptoms are most often reported after handcuffs or tight

ropes at the wrist. Lesions of the brachial plexus, especially the lower roots, have been mentioned after suspension, and damage of the long thoracic nerve has been reported after “Palestinian hanging”¹⁸.

Many of the long lasting symptoms like loss of concentration, headache, memory disturbance, and vertigo, could be explained by chronic, organic brain damage³³ and call for a neurophysiological evaluation in order to evaluate the specific symptoms. It should, however, be born in mind that many of these symptoms are also related to PTSD.

Moreno and Grodin²⁰ have published a detailed review article on torture and its neurological sequelae.

Cardiopulmonary

Acute symptoms include dyspnoea, chest pain, cough, expectoration and palpitation.

Certain types of torture lead particularly to pulmonary complications. Beatings to the chest can cause damage to the thoracic wall, including rib fractures, and severely reduce respiration. Often the consequence will be pneumonia. “Wet submarino” is associated with the potential risk of producing acute lung symptoms due to aspiration of contaminated water. Harsh prison conditions in humid, cold and dark cells probably often facilitate pneumonia, bronchitis or pulmonary tuberculosis.

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Electrical torture may produce cardiac arrest if the current passes through the heart³⁴.

Long lasting symptoms in a follow-up study of 22 Greek torture victims³⁵ showed that attacks of tachycardia, palpitations and/or dyspnoea, also combined with anxiety, were found in 6 out of 22; pain in the thorax, including angina and muscular pain in 5 out of 22; and chronic bronchitis (cough, exertion dyspnoea) in 8 out of 22 persons. These findings highlight the importance of follow-up studies on torture victims.

Significant ECG changes have been observed in US soldiers held in detention camps in Serbia³⁶

Gastrointestinal

Acute torture related symptoms are described after having a foreign body inserted into the anus. Lesions of the anus and rectum have been described as a consequence of the torture. The lesions give rise to pain and bleeding. Obstipation is often a secondary symptom to anal pain. On examination of the anus, the following findings should be looked for and documented⁸:

- i Fissures tend to be non-specific findings as they can occur in a number of “normal” situations (constipation, poor hygiene). However, when seen in an acute situation (i.e. within 72 hours) fissures are a more specific finding and can be considered evidence of penetration.
- ii Rectal tears with or without bleeding may be noted.
- iii Disruption of the rural pattern may manifest as smooth fan-shaped scarring. When these scars are seen out of midline (i.e. not at 12 or 6 o'clock), they can be an indication of penetrating trauma.
- iv Skin tags, which can be the result of healing trauma.

- v Purulent discharge from the anus. Cultures should be taken for gonorrhoea and chlamydia in all cases of alleged rectal penetration, regardless of whether a discharge is noted.

Acute gastroduodenal haemorrhage has been reported by a small number of torture victim survivors, and may be explained by the extreme stress.

Acute gastrointestinal symptoms such as abdominal pain, epigastric discomfort, diarrhoea, vomiting, etc. are associated with torture and imprisonment. These symptoms must be considered to be of mixed aetiology, in which mechanisms caused by the stressful situation may be a factor. Insufficient or unappetising food, restriction of liquids and lack of exercise may also be factors related to these gastrointestinal symptoms during imprisonment.

The incidence of gastrointestinal symptoms in the torture victims at the time of medical examination was the same as that of control groups and of the population at large.¹

Urological

Severe beating to the kidney region can give rise to development of haematoma in and/or around the kidney. In many cases the lesion is accompanied by haematuria.

Direct trauma to the urethral mucous membrane either by beating or electric torture in the urethra also produce haematuria. Beating at the scrotum can injure testes with subsequent atrophial³³.

Haemoglobinuria can be mistaken with haematuria. Haemoglobinuria has been described in runners due to “footstrike” hemolysis³⁷. The same mechanism might explain the “Haematuria” in some of the torture victims. Falanga in particular (beating on the soles of the feet) is somewhat similar to the

constant friction of the feet as they strike the ground in runners. Among 34 persons with acute renal failure admitted to hospital after alleged torture in Police interrogation centres in Kashmir, only those who were beaten on soles had evidence of haemoglobinuria³⁸.

To distinguish haemoglobinuria from haematuria a centrifuge of the urine should be done. The erythrocyte will precipitate, which will not be the case of haemoglobinuria.

Myoglobinuria occurs as a result of rhabdomyolysis, destruction of the muscle tissue, and may be caused by beating, or electrical torture³⁹. The urine is red or brownish and could be mistaken for blood.

Myoglobinuria is a potential dangerous condition as it causes damage to the kidneys with serious risk of acute renal failure⁴⁰.

Dysuria is a frequent complaint among torture victims, probably caused by torture instruments in some of the cases, and by cold and poor hygienic conditions in the rest.

Long lasting bladder and/or kidney complaints have not been reported more frequently in torture survivors than in control groups.

Otorhinolaryngological

The type of torture that carries a high risk of damaging the hearing functions is beating, particularly in the form of “teléfono” in which both ears are beaten simultaneously with the flat of the hand.

“Teléfono” produced immediate as well as long lasting symptoms from the ear¹. It produces a shock wave against the eardrum, probably very similar to the one produced by explosions. Kerr⁴¹ describes the clinical observations after blast injuries in Belfast:

“Usually sensorineural deafness occurs accompanied by tinnitus. In mild cases this tinnitus and deafness may recover fully in

a matter of hours. Severe cases may never recover fully. Perforation of the tympanic membrane is common and occurs in pars tensa which is the lower five-sixths of the tympanic membrane. These perforations vary in appearance and may be linear tears, small holes or subtotal defects. From time to time, there is also damage to the ossicular chain.

Especially high frequency sensorineural deafness occurs with preserved normal hearing for the speech frequencies. The hearing loss may recover up to six months after the explosion.”

Ophthalmological

Acute eye symptoms in torture survivors are conjunctivitis, probably caused by dirty cloths used for blindfolding which the victims often had to wear day and night for many days.

Very few long lasting eye symptoms, possibly related to torture, have been described.

Perron-Buscail, Lesueur, Chollet, and Arne⁴² observed opacities in the cornea 10 years after electric torture in the eyes, influencing the vision.

Gynaecological examination

Throughout history sexual harassment of women has been a weapon of war and power⁴³. In many countries, acts of sexual violence are a common method of torture or inhuman treatment inflicted on women⁴⁴. It is found that female victims of torture are raped more often than men although men are also frequently subjected to rape⁴⁵. Gender-based and sexual violence of refugees is a frequently hidden problem. Violence might have taken place during the conflict, the flight, or in the country or place of asylum. There might have been random acts of sexual assault by enemy troops, or border guards, or rape may be used as a deliberate

act of war. Women may have been forced to offer sex for survival, or in exchange for food, shelter or protection. Young girls and women who are alone are often at greatest risk⁴⁶. Refugee women from any age may be raped, women over 60 years of age or children⁴². It must be emphasised that genderbased violence and rape may be only one among many traumas that women have suffered, and that physical consequences are often accompanied by psychological and social consequences.

The impact of gender-based abuse on physical health can be immediate and long-term. However, women who are abused rarely seek medical care for acute trauma⁴⁸. Seeking medical care is often not an option for refugee and internally displaced women. Many victims of sexual violence and rape never talk of sexual violence. Barriers for seeking medical care may be reduced by ensuring a sufficient number of female health care workers, and by training health professionals working with refugees and torture victims to recognise victims of sexual violence and rape. It is important to allow the victim sufficient time to disclose the trauma. Even when refugees do not directly seek assistance, they often present multiple somatic, mental and social complaints.

Before gynaecological examination the purpose of the examination should be clear: is it to identify treatment needs or is it to document alleged sexual abuse? In case of documentation of human rights abuses for legal purposes it is essential to collect detailed information. It is important that the alleged victim gives her informed consent. When examining victims of sexual violence, every precaution should be taken to minimise retraumatisation. A safe and confidential environment should be ensured. Cultural differences, religion and traditional beliefs may affect the meaning given to experiences,

the symptoms expressed, and how people cope with the violent experiences⁵⁰.

A detailed medical, obstetric and gynaecological history should be taken, including questions on sexual activity, menstruation, and contraception. Physical signs after sexual violations and rape depend very much on the interval between the assault and the examination. Immediately after the rape of a woman semen may be detected. She may have injuries all over her body. There may be bruises and bite marks, on the lips, neck, shoulders, buttocks, and breasts. The vulva, vagina, the anus, and the urethra should be carefully examined and special attention should be paid to the perineum. There may be external signs of perineal tears, with laceration of the margin of the vaginal introitus or anus. Where injuries are gross, fistulae between vagina and the rectum may be seen. The presence and condition of a hymen should be noted⁵¹. After electrical torture and/or blows in the genital region, haematuria may be found, due to injuries to the urethra and bladder⁵². Most of the acute symptoms disappear in time, and it may not be possible to differentiate scars of the perineum from scars after childbirth or scars following a sexually transmitted disease.

Later, women may present themselves with complaints of vaginal bleeding, decreased sexual desire, genital irritation, pain during intercourse and urinary tract infections⁵³. Sexual torture may leave traces in the musculo-skeletal system, structural injuries, functional disturbances, and dysfunctioning of the pelvic joints in women. They often have lumbar pain, and complain about pains in the genitalia, menstrual disturbances, and sexual problems⁵⁴.

Damage to the genitals is most severe in girls under 15, and in girls and women who have previously been subjected to female genital mutilation. These girls and women

are also at higher risk of contracting Sexually Transmitted Diseases (STDs) or Human Immuno-deficiency Virus (HIV). Health care workers should always consider sexually transmitted diseases after rape. Soldiers, even during peacetime, have STD infection rates 2 to 5 times higher than those of civilian populations. The chance of infection is therefore considerable for women who have been raped by soldiers⁵⁵. Consequences of pregnancy and delivery, as well as of an unsafe abortion must be considered. The most frequent complications are incomplete abortion, sepsis, haemorrhage, and intra-abdominal injury, such as puncturing or tearing of the uterus⁵⁶.

Examination of children*

Many cases of torture of children have been documented by human rights organisations and it is feared that those cases form only the tip of the iceberg⁵⁷. However, there is a general disbelief that torture can be perpetrated against children. A reason for this disbelief may be that the Western concept of a child as an economically dependent, politically uninvolved individual fits very few children in the world⁵⁸. Torture and sexual abuse of children are widespread, particularly in conflicts dominated by ethnicity⁵⁹. The girl child is double susceptible to violence, because of her gender and because of her age⁶⁰.

Children may be secondary torture victims, because of the violence or torture perpetrated against one or more of their relatives. They may also be primary victims. As there are many reports on how children have been subjected to the same torture methods

as adults, it may be expected that they have similar physical symptoms as adults. Still, very little is known of physical consequences of torture that are typical for children. What are the implications of torture for a growing body? How does torture affect the development of a child?

Children should be examined in a way appropriate for their age, nevertheless, the health professional should realise that for many of the world's children, childhood ends long before they reach the age of eighteen, the age when according to most international standards they become adults. Their stories on the violence suffered by them should be respected and taken seriously. However, they often prefer to stay silent, move away, and hide and bury their experiences⁶¹. Children may react to trauma with depression, sleep disturbances, nightmares, anxiety, fears, learning problems, posttraumatic stress disorder, and feelings of guilt and self-blame⁶². When examining refugee children attention should be paid to general health signs, and specifically to signs of malnutrition. Malnutrition in refugee children is often caused by a chronic lack of food, but it may also be a sign of child abuse. In the differential diagnosis, it is important to distinguish severe weight loss from chronic pyogenic or urinary infections, tuberculosis, syphilis, AIDS, and tropical infestations⁶³.

After a traumatic event children may suffer from enuresis and, less frequently, from encopresis⁶⁴. Nocturnal enuresis is rather common in children of school age. It occurs more often in boys than in girls. There is a strong association with a family history of bedwetting. Regressive enuresis (occurs after children were previously dry) can be triggered by stressful events. Physical examination and urinalysis are indicated to exclude organic damages, but organic pathology can be found in only a very small number of

*) The definition of "child" in the UN Convention on the Rights of the Child states: "For the purpose of the present Convention, a 'child' means every human being below the age of eighteen years, unless, under the law applicable to the child, majority is attained earlier."

cases. Possible differential diagnoses are urinary tract infections (especially in girls) and diabetes mellitus. Encopresis is less common than enuresis. It is a problem that in most cases develops as a result of long-standing constipation. It may represent emotional problems. As in the case of enuresis, organic defects are rarely found, but should be excluded.

It could facilitate the recognition of physical consequences of torture if health professionals are familiar with the physical consequences of other non-accidental injuries in children. The shaken infant syndrome has been described as occurring only in very young children, seldom older than 2 years of age. However, symptoms similar to the shaken infant syndrome have been diagnosed in an adult who had been subjected to shaking during interrogation³². There has been no systematic study of morbidity amongst the many people who have been submitted to shaking during interrogation.

Future research

The preventive effect of teaching the principles of the Istanbul protocol to the medical and legal profession in countries where torture is practised should be studied.

Descriptions of changes in the skin following torture have been performed in several areas of the world, particularly in the recent quarter of a century. As with other skin changes, a systematic registration, photographs included, is important also for the years to come in order to obtain a continuously increasing background to be able to support an allegation of torture as objectively as possible.

Since our knowledge of specific histologic alterations in the skin following an electrical injury, epidermal changes included, is mainly based on experiments on fully anaesthetised pigs, while only a few hu-

man cases have been examined, it would be of importance for the preventive influence of our studies, following a local anaesthesia, to obtain a 3-4 mm punch biopsy from electrically influenced areas of the human skin. Histologic examination of skin biopsies is used as routine method in the diagnosis of skin diseases.

Most of the published literature on the musculo-skeletal consequences of torture is descriptive, listing symptoms and signs without diagnoses. Research focusing on the aetiology and pathogenesis of the long-lasting symptoms, including pain, is missing, and systematic information on dimensions of health other than reporting of symptoms and illness, e.g. health related quality of life including physical functional ability in torture victims, is not available.

Future research related to the specific musculo-skeletal consequences of physical torture should include systematic clinical and radiodiagnostic evaluation in order to establish diagnosis for documentation and rehabilitation purposes. It should also focus on overall physical function and other aspects of health-related interference with quality of life.

Long lasting physical sequelae should be systematically examined including a control group.

Research on the effects of torture on children is still in an early stage. Most studies describe the psychological consequences of torture. Further research would be needed to learn more about the prevalence of torture cases among children and the consequences that torture has on a growing body, in order to develop effective rehabilitation programs that also reach these least visible victims of torture.

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