ABSTRACT

Educational Objective: At the conclusion, participants should be able to recognize manifestations of torture to the head and neck.

Objectives: Amnesty International reported that torture occurred in 102 countries in 2007, and many torture survivors seek refuge in the United States. Physicians are often not trained to recognize torture, and survivors are often reluctant to discuss their experiences. The Educational Objective is to review common methods and manifestations of head and neck torture in order to provide otolaryngologists and referring physicians with an improved framework for recognizing and treating torture to the head and neck.

Methods: A case series of torture survivors (using UN definition of torture) is presented and includes demographics, torture history including political context, medical, and psychiatric history, physical exam, radiologic studies, diagnosis, and treatment.

Results: Patients who presented with a history significant for head and neck torture were reviewed. Physical and/or obvious findings are not always present in survival and torture survivors are often reluctant to offer their histories, and clinicians may not inquire about torture history.

Conclusions: Recognition and treatment of the manifestation of head and neck torture are important when treating asylum seeking and refugee populations, including appropriate referrals to specialized center for survivors of torture.

INTRODUCTION

The United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment defines torture as “any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession … and when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.”

INTRODUCTION

Case 1

• 35-year-old man from the Middle East who reported that he was detained and beaten in a prison camp because of his Christian religious affiliation.

• He presented with complaints of episodic dizziness, difficulty with ambulation, and otalgia.

• These symptoms were not initially described to the patient’s primary care physician, as he later reported associated feelings of shame regarding the origin of his symptoms.

• Physical exam: slower, broad-based gait with closed eyes and an abnormal Romberg tandem. Dix-Hallpike exam revealed right side down horizontal nystagmus without latency.

• Vestibular and audiometric testing revealed left sensorineural hearing loss with otherwise negative electrocochleography.

• The suspected diagnosis was post-traumatic disequilibrium secondary to left oval window fistula. He was taken to the operating room for exploratory tympanotomy that revealed pooling of fluid around the oval window, confirming the diagnosis. Fat harvested from the pretragal tissue was used to repair the defect.

Case 2

• 59-year-old woman who was a member of an opposition political party in Central Africa. She was captured and beaten unconscious on two separate occasions in 1998 and 2002.

• She presented with significant facial scarring and complaints of excessive tearing, rhinorrhea, and a collapsed left nostril.

• Physical exam: Scarring of the left eyelid with retraction and partial alopecia, and scar over V1 and V2 distribution.

• The patient was offered surgical repair for of the nasal vestibular stenosis and scar revision of lower eyelid and right nasal alar area. After discussing her options, the patient chose to defer treatment until the resolution of her legal issues and has not yet returned to clinic.

METHODS AND MATERIALS

We reviewed the medical records of patients referred to the Department of Otolaryngology from the Boston Center for Refugee Health and Human Rights from January 2002 through January 2008.

Eligibility criteria included women and men greater than or equal to 18 years of age who were survivors of torture by the UN definition, and who had suffered otolaryngologic injury as a result of the torture in their home countries. Of the six cases reviewed, three cases were identified where the head and neck pathology was related to their reported experiences and was consistent with the history provided. The severe pain, or suffering, or symptoms described by the patient is typical of otolaryngologic injuries.

METHODS AND MATERIALS

Case 3

• 49-year-old man who was a member of an opposition political party in Eastern Africa. He was captured and tortured on several occasions, sustaining multiple injuries including avulsion of his auricle with a sharp object.

• He presented with significant deformity to the left auricle.

• Initially, he had reported that his injuries were incurred in a motor vehicle accident.

• Physical exam: Severed left ear with approximately two-thirds of the superior helix and triangular fossa absent. The superior aspect of his external auditory canal was stenotic.

• He underwent auricular reconstruction with a Medpore framework, temporalis fascia flaps, and split thickness skin graft from the newer lower extremity.

DISCUSSION

• Trauma to the head is common in survivors of torture, with Rasmussen et al reporting an incidence of 73% among a cohort of survivors. Survivors may present with obvious injuries such as facial trauma, or with less obvious symptoms such as vertigo, hearing loss, or sinus pain. Sinusitis is reported in a survivor subjected to torture methods that utilize water.

• Torture may be difficult to identify in the clinical setting, as survivors may be reluctant to offer their histories, and clinicians may not inquire about torture history.

• It is important to consider a patient’s country of origin, immigration status (refugee or asylum seeker) and flight history when evaluating otolaryngological symptoms. Medical documentation of torture may be required to support an asylum application.

CONCLUSIONS

• This report serves to increase the awareness of survivors of torture in clinical practice, and to advance the clinical understanding of the otolaryngologic sequelae of torture.

• As awareness increases, we hope to define the most common forms of otolaryngologic torture, acute/long term sequelae, and the prevalence of these injuries.

• In the future, we may be able to improve the identification and access to care offered to survivors of torture from around the world.

REFERENCES


