

Skin Changes after Torture

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Torture leaves many types of change in the skin. Their main significance is that they can be used diagnostically to support an allegation of torture. They rarely inconvenience the patient, but can sometimes be of cosmetic importance since they may add to the changed sense of identity induced by the torture.

The following method of examining and assessing skin changes following torture will primarily be aimed at the diagnostic possibilities afforded by the examination.

The history should include: 1) information on skin disease prior to the torture; 2) as detailed an account as possible of the origin of the skin lesions, with particular respect to the shape and size of applied instruments (if any) and the type of energy transferred to the skin, e.g. electrical energy, heat energy; 3) description of the appearance and duration of acute lesions and information on the localization of any permanent changes.

The physical examination should include: 1) examination of the entire skin to detect signs of generalized skin disease; 2) description of the localization, symmetry, shape, size and colour of the scars and their demarcation and level in relation to the surrounding skin; 3) photographing of the scars; 4) punch biopsy (if necessary).

Important considerations when drawing conclusions from the examination are: 1) an attempt to compare the details stated about the origin of the lesions with the objective findings, 2) possible differential diagnoses in relation to non-torture-related skin changes.

The examining doctor must be familiar with the characteristic skin changes that follow the most frequently applied types of torture, and with their differential diagnoses.

Torture sequelae located to the skin

Torture sequelae located to the skin may be:

1. Scars resulting from direct physical injuries.
2. The occurrence of new, or aggravation of existing skin diseases, provoked by physical or psychological trauma.

Most of these sequelae resolve soon after the torture. Permanent changes in the skin due to blunt trauma are infrequent, uncharacteristic, and usually without diagnostic significance.

An exception is flogging, which may leave long, straight or curved linear scars in asymmetric patterns (Fig. 1). The scars are depigmented and often hypertrophic, surrounded by narrow, hyperpigmented stripes (Fig. 2). The only differential diagnosis is plant derma-

titis, but this is dominated by hyperpigmentation and shorter scars (Fig. 3).

By contrast, symmetrical, atrophic, depigmented linear changes, which are sometimes claimed to be torture sequelae, represent striae distensae (Fig. 4) and are not normally related to torture.

Another sequela of blunt violence which may be used diagnostically is a linear zone extending circularly around the femur, and which is claimed to have occurred after the application of tight cords (Fig. 5). The zone contains few hairs or hair follicles, probably a form of cicatricial alopecia. No differential diagnosis in the form of a spontaneous skin disease exists, and it is difficult to imagine any trauma of this nature occurring in everyday life.

Sharp violence often leaves permanent scars, but they are often uncharacteristic and without substantial diagnostic significance.

An exception is razor blade lesions, which are 5-10 mm long, 1 mm wide, linear, often depigmented and macular scars (Fig. 6). If pepper is applied to the open wounds, they may become hypertrophic (Fig. 7). An asymmetric pattern and different sizes of scars (Fig. 8) are probably significant in the diagnosis of torture changes. A possible differential diagnosis is ritual tattooing with scars, though little is known about this. In Africa it is performed with razor blades and subsequent application of ashes in order to produce a regular and aesthetically beautiful pattern (Fig. 9).

Burning is the form of torture that most frequently leaves permanent changes in the skin. Sometimes, they may be of diagnostic value.

Cigarette burns often leave 5-10 mm large, circular and macular scars with a depigmented centre and a hyperpigmented, relatively indistinct periphery (Fig. 10). The burning away of tattoos with cigarettes has also been reported in relation to torture (Fig. 11). The characteristic shape of the resulting scar and any tattoo remnants will help in the diagnosis. Surgically removed tattoos constitute a differential diagnosis, but dermabrasions and excisions usually produce rectangular and striped scars.

Burning via the transfer of larger amounts of energy to the skin than that used when stubbing a cigarette on the skin often produces markedly atrophic scars. They are sharply demarcated with narrow hypertrophic or hyperpigmented marginal zones. This may for instance be seen after burning with a gas lighter (Fig. 12) or an electrically heated metal rod (Figs. 13 and 14). It is difficult to imagine any differential diagnosis if many scars result. Spontaneously occurring inflammatory processes would probably lack the characteristic marginal zone and only rarely exhibit such a pronounced loss of tissue.

When the nail matrix is burnt, subsequent growth produces striped, thin, deformed nails, sometimes broken up in longitudinal segments. If the nail is also pulled off, an overgrowth of tissue may occur from the proximal nail fold, resulting in the formation of pterygium (Fig. 15). Changes in the nail caused by lichen planus constitute the only relevant differential diagnosis, but they will usually be accompanied by a widespread skin affection. Fungus infections, on the other hand, are characterized by thickened, yellowish, crumbling nails, (Fig. 16) different from the above changes.

Electrical torture often leaves scars on the skin. "Picana", performed with pointed electrodes, may give distinct lesions, 1-2 mm wide.

Immediately following "picana", clusters of such lesions covered by reddish-brown crusts may be observed, usually without the surrounding inflammation seen after burns (Figs. 17 and 18). Some of the lesions leave scars appearing as clusters of hyperpigmented macules without any sequelae resulting from inflammatory reactions in the periphery (Fig. 19). Insect bites might constitute a differential diagnosis, but these are often accompanied by inflammatory reactions in the periphery and are unlikely to leave cicatrization.

An example of skin diseases being psychologically provoked by torture may be the concomitant occurrence

of an urticarial eruption. Physically provoked skin diseases may be the development of psoriasis or lichen planus in the traumatized area, as a "Köbner-reaction" (Fig. 20). However, such skin changes have little diagnostic significance in relation to torture.

Conclusion

The diagnostic value of macroscopic changes in the skin is often limited. While few and uncharacteristic scars can support the allegation of torture only to a limited extent, characteristic changes may, on the other hand, offer substantial evidence, particularly if they occur in large numbers.

COMMENT:

The 20 illustrations of skin changes after torture inserted in the middle of this issue of TORTURE are available as slides and can be obtained by sending a request to:

The Danish Medical Group
Amnesty International
Dyrkøb 3
DK-1166 Copenhagen K

Price: £ 8

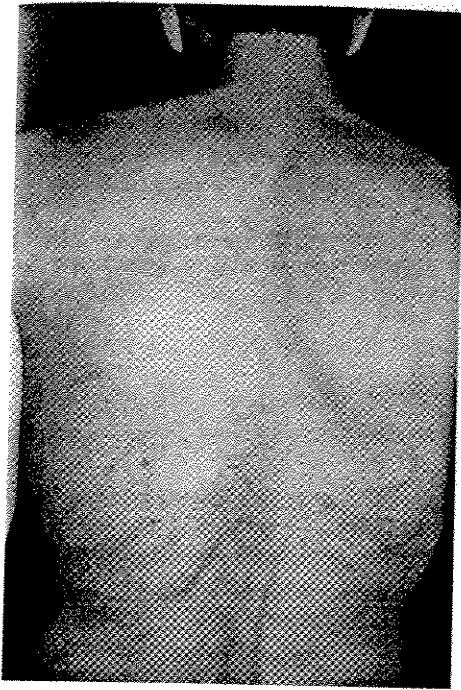


Fig. 1.: Long, straight or curved, linear scars in an asymmetric pattern on the back, 6 months after flogging. The scars are depigmented, hypertrophic and surrounded by thin, hyperpigmented stripes.

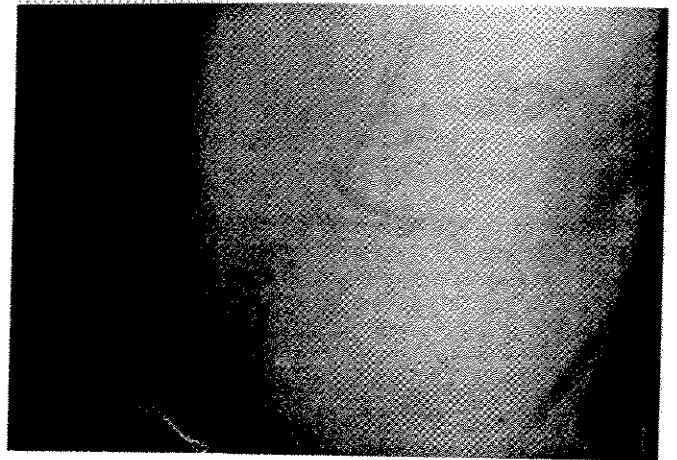


Fig. 2.: Straight and curved linear scars, 6 months after flogging. The scars are depigmented, hypertrophic and surrounded by thin, hyperpigmented stripes.



Fig. 5.: Linear zone, extending circularly around the leg, 6 years after hour-long application of tight cords. It is probably a case of cicatricial alopecia, caused by the torture.

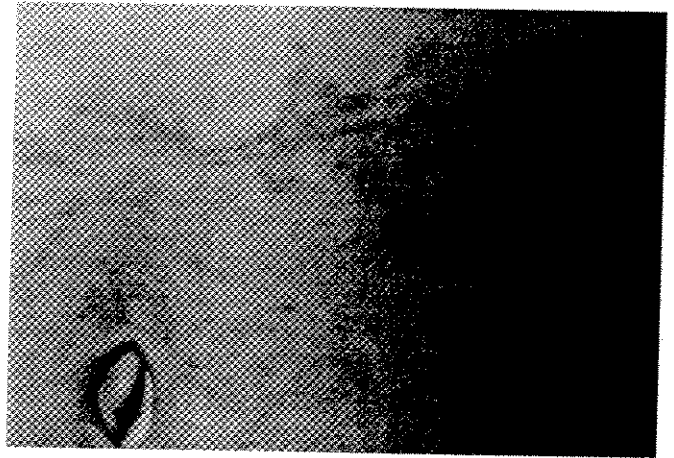


Fig. 3.: Plant dermatitis with short, hyperpigmented scars.

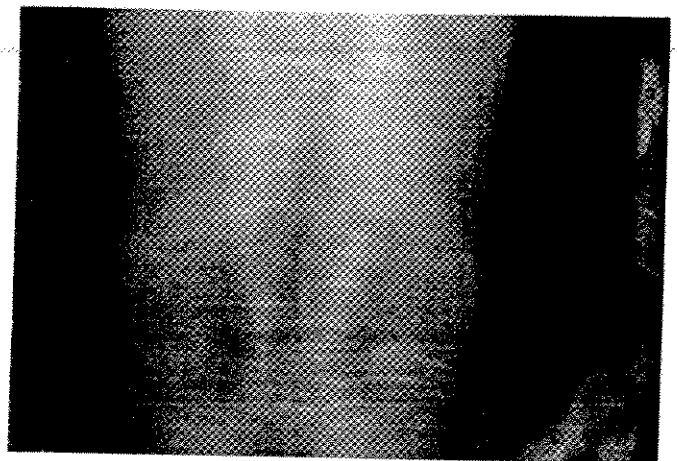


Fig. 4.: Symmetrical, atrophic, depigmented, linear changes on the back, allegedly occurring 2 years after beating and scalding. The patient had similar changes in both axial regions. It is a case of striae distensae without relation to torture.

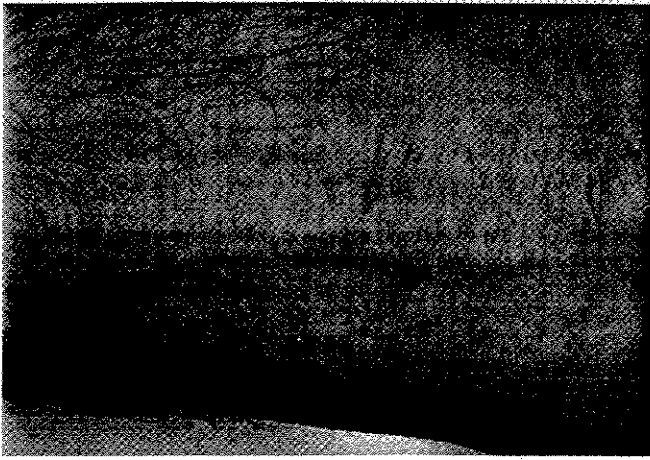
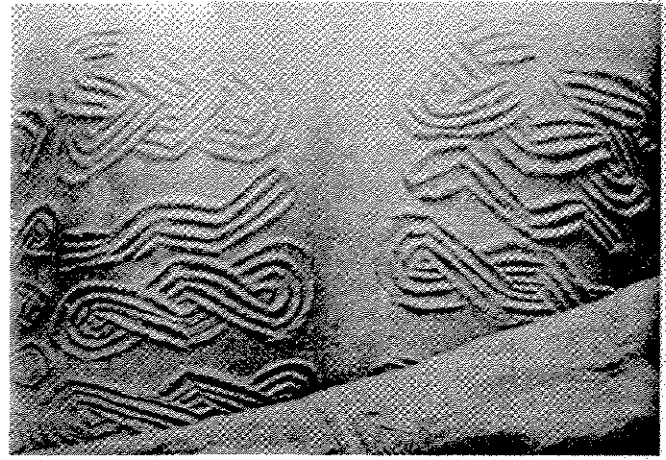
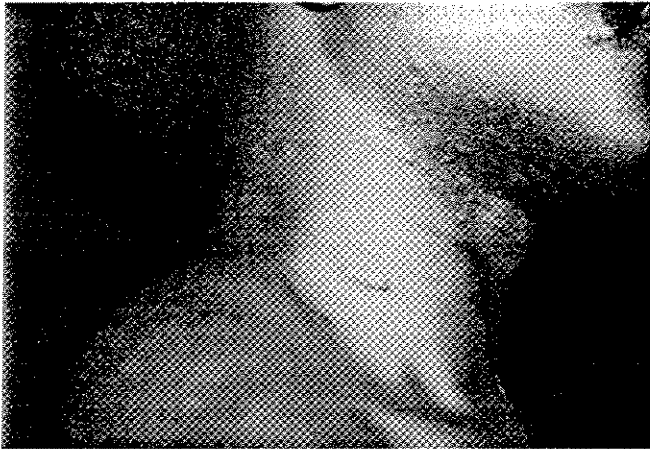


Fig. 6.: Numerous 5-10 mm long, 1 mm wide, linear, depigmented and macular scars, 3 years after torture with razor blades.



*Fig. 9.: African ritual scar-tattoos in a regular and aesthetically beautiful pattern made by razor blades and the application of ashes (Søren Nancke-Krogh: *Kunsten på kroppen (Art on the Body)*, Copenhagen, 1985).*



Figs. 7 and 8.: Numerous 5-15 mm long, 1-3 mm wide, linear and irregular scars on each side of the neck, 2 years after torture in Africa with razor blades and the application of pepper to the open wounds. The scars are asymmetrically localized and irregular in shape and size.



*Fig. 10.: Approx. 5-10 mm large, circular and macular scars with a depigmented centre and a hyperpigmented, relatively indistinct periphery, 4 weeks after burning with a cigarette (Aa. R. Kjærsgaard and I. K. Genefke, *Ugeskr. Læg* 1977:139,1057).*

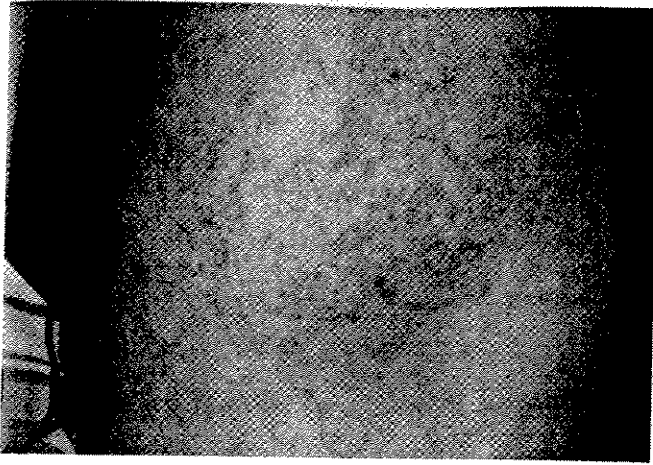
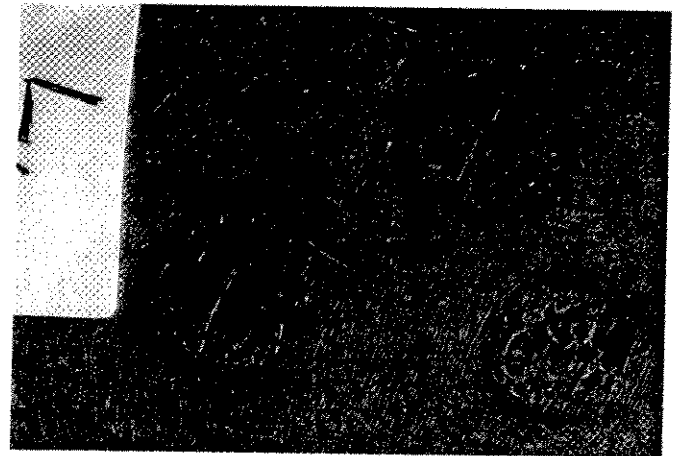
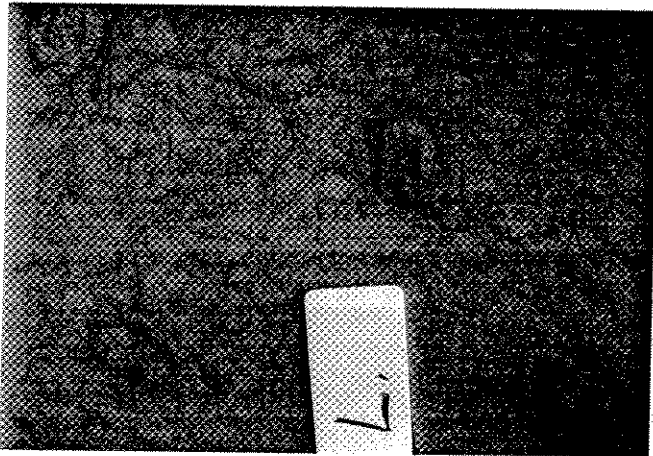


Fig. 11.: Heart-shaped scar consisting of closely set depigmented patches measuring a few mm across, surrounded by hyperpigmentation and containing tattoo remnants 4 years after the burning away of the tattoo with two packets of cigarettes during torture.



Fig. 12.: Circular, atrophic scars with a narrow hypertrophic marginal zone 10 years after burning with a gas lighter.



Figs. 13 and 14.: Circular and oval scars with an atrophic centre and a narrow hypertrophic or hyperpigmented marginal zone 1 year after burning with an electrically heated circular metal rod the size of a cigarette. The patient had 35 such scars (L. Danielsen and Ph. Berger, Acta Dermatovener, Stockholm 1981:61,43).



Fig. 15.: Striped, deformed toe nails, the left big toe nail divided into 3 slightly curved longitudinal segments with overgrowth of tissue from the proximal nail fold resulting in the formation of pterygium, 2 years after injury to the nail matrix caused by the pulling off of toe nails and burning with charcoal embers.

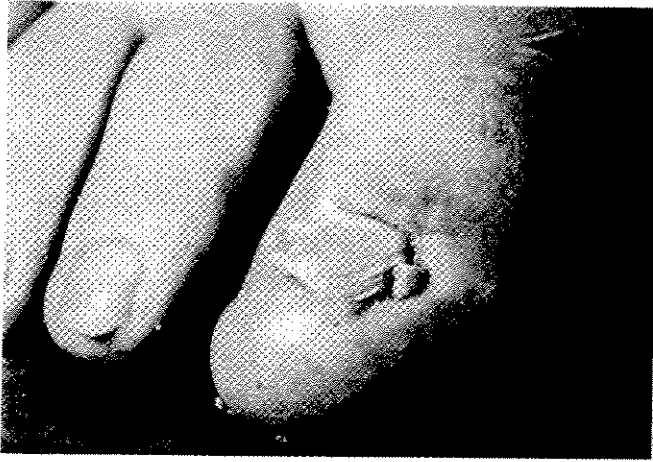
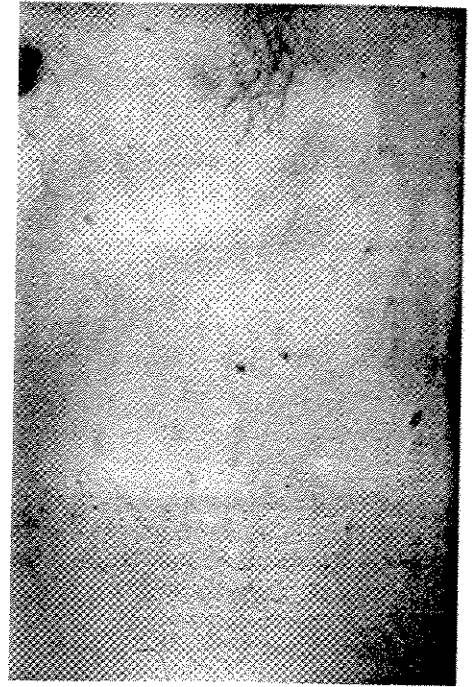


Fig. 16.: Thickened, yellowish toe nail caused by mycosis.



Figs. 17 and 18.: 1-2 mm large lesions with reddish-brown crusts and red stripes a few hours after "picana". The lesions on the legs are without surrounding inflammation, but slight surrounding inflammation can be seen in the lesions on the abdomen (Ole Vedel Rasmussen, doctoral thesis).

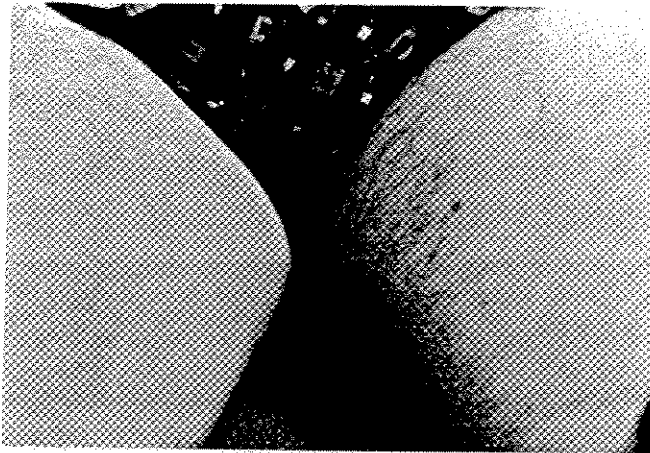


Fig. 19.: One mm wide, macular, hyperpigmented scars, 4 weeks after "picana". There is no marked marginal zone (Aa. R. Kjærsgaard and I. K. Genefke, Ugeskr. Læg 1977:139,1057)

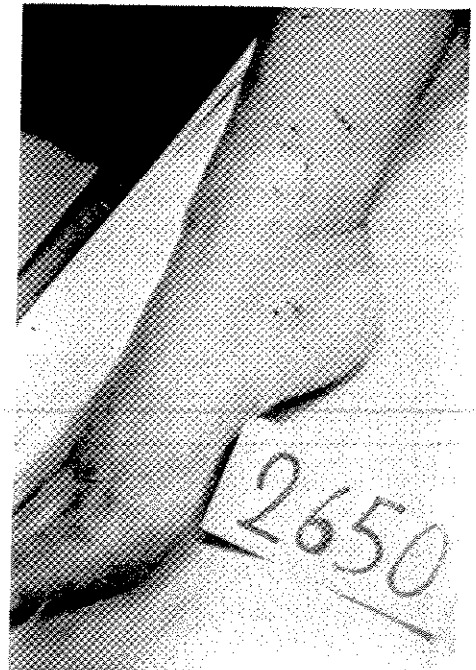


Fig. 20.: Lichen planus (verified by biopsy) on the front of the shin, 12 years after kicks during torture, possibly a "Köbner-reaction" to this.

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