

OUTCOME OF MANAGEMENT OF GUNSHOT INJURIES BY NIGERIAN TRADITIONAL DOCTORS

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SUMMARY

Four patients with gunshot injuries who were managed by Nigerian traditional doctors are presented. They finally presented to us with some avoidable complications which was successfully managed in three of these patients while one of them died. The first patient with abdominal gunshot injury died of septicaemia after being managed conservatively by the traditional doctor. The second patient had Pneumothorax as a result of gunshot injury to the chest. The conservative management by the traditional doctor failed so we had to insert chest tube and underwater seal drainage. The third patient had tetanus from gunshot injury while being managed by traditional doctor. He responded favourably to orthodox management. The fourth patient had embedded pellets following a gunshot injury which were removed by us. He was earlier deceived by the traditional doctor who claimed that he had removed the pellets diabolically. The morbidity and mortality of the management of gunshot injury by traditional doctors in Nigeria is quite high. We therefore recommend strict regulation of their activities.

KEY WORDS: Gunshot injuries, Traditional doctors.

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INTRODUCTION

Gunshot injuries are very common in Nigeria because of legally and illegally acquired firearms by the community. The commonest cause of gunshot injuries in developed countries is suicidal attempt.¹⁻⁴ However, armed robbery is the commonest cause of gunshot injury in Nigeria as in most other developing countries.⁵⁻⁸ In developed countries most of the victims enjoy orthodox medical management.^{2,3} In Nigeria there is poor utilization of

orthodox health facilities especially in the rural community.^{9,10} This is most obvious in the management of gunshot injuries as most victims go to the traditional doctors after the injuries. Even some of the patients rushed to the hospitals request for discharge against medical advise to enable them go for traditional treatment. Several reasons have been adduced why some patients with gunshot injuries prefer to be managed by traditional 'doctors'.^{9,10} Some of the reasons include:

1. Most of our people cannot afford the fee for orthodox treatment while traditional 'doctors' fees is usually very low.
2. A good number of traditional 'doctors' attend to their patients at home
3. The traditional 'doctors' are good psychotherapists who are believed to be in possession of some supernatural powers. They blame the avoidable complications arising from their unorthodox management on forces like witches or contravention of some spiritual laws by the patients.

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However, most of the patients end up with rather severe avoidable complications while many die.¹¹ The few that recover are those who could have done well even without the traditional 'doctors' intervention.

The aim of this paper is to present some gunshot injuries cases that were managed by Nigerian traditional doctors highlighting the avoidable complications of such treatment.

CASE ONE: I.O., a 32year old male presented with a day history of gunshot injury by armed robbers few hours before presentation. He had severe abdominal pain with multiple pellet wounds on left iliac fossa. Fig-I The vital signs were stable, he was not pale, not jaundiced and the only significant finding was generalized abdominal tenderness and multiple pellet wounds on left iliac fossa. He had plain abdominal x-ray and was prepared for laparotomy. His father however requested for discharge against medical advise and took him to a traditional doctor. The traditional doctor massaged his abdomen with some herbal material spitting into the wounds after some incantations and presented some pellets to the patient. He claimed that the pellets were removed from the patient's abdomen.. The patient however did not improve. Two weeks later he was rushed back to our hospital. On examination he was toxic, dehydrated, jaundiced, pale restless and gasping. The blood pressure was 80/20mmHg and the pulse rate was 123 beats per minute. Attempt at resuscitating him failed and he was certified dead after 40 minutes. The family members refused to have postmortem but the likely cause of death was septicaemia secondary to bowel perforation and faecal peritonitis.

CASE TWO: A.I. is a 35-year-old police officer was shot in the chest by armed robbers while on duty. He was immediately rushed to a traditional doctor who massaged his chest with some herbs and spat on the wounds after making some incantations claiming that the pellets have been removed. The patient however became progressively dyspnoeic and was rushed to our hospital by the family. On

examination he was dyspnoeic, tachypnoeic and restless. He had tachycardia (pulse rate of 135/min) and hypotension (blood pressure of 70/30 mmHg). The percussion note on the left hemithorax was hyperresonant. He became less dyspnoeic after insertion of a wide bore needle through the left second intercostals space in midclavicular line. Chest x-ray confirmed many pellets in the left hemithorax and left pneumothorax. He was given antibiotics; anti-tetanus prophylaxis, analgesics and the wounds were dressed after insertion of a chest tube through the left second intercostal space midclavicular line. The chest tube was connected to an underwater seal bottle. The air bubble stopped after the 4th day and repeat chest x-ray confirmed satisfactory re-expansion of the left lung. The chest tube was removed on the tenth day and the patient was later discharged.

CASE THREE: Mr. O.O. was a 15year old boy who sustained gunshot injury to his back by armed robbers while traveling in a bus. He was rushed to a traditional doctor who massaged the back with some herbs and spat on the wound after making some incantations. He also claimed that he had removed some pellets from the wound by incising the skin over the palpable pellets with an unsterile blade and extracting the palpable pellets. Six weeks later he had difficulty in opening his mouth and reported to the traditional doctor who forced the mouth open to administer some herbs. He was however rushed to our hospital when he further deteriorated. On examination he was ill looking, dehydrated and pale. The vital signs were okay but he had multiple pellet scars on the trunk. He had trismus, abdominal rigidity and occasional spasms. The impression of tetanus was made and he was resuscitated, given therapeutic dose of anti tetanus serum, antibiotics and muscle relaxants. He had slow but steady improvement and was discharged five weeks later.

CASE FOUR: Mr. O. A. was a 45year old driver who was shot by some armed robbers while trying to snatch his bus. He was immediately

rushed to a traditional doctor who massaged his chest with some herbs and spat on the wound after making some incantations. He thereafter gave him some pellets claiming that they were removed from his body. The wounds got healed and he was thereafter perfectly okay. However two years later he noticed two small hard masses on the posterior aspect of his left hemithorax. He presented in our hospital and on examination he had two hard freely mobile masses on the posterior aspect of his left hemithorax each measuring about 2 millimeters in diameter. The two palpable pellets were removed after infiltration of 1% xylocaine with adrenaline.

DISCUSSION

Discharge against medical advice is very common Nigeria.¹² Most patients with gunshot prefer traditional medical treatment to the orthodox treatment and so they usually end up with the traditional doctors. This practice should be discouraged as most of the patients end up with rather severe avoidable complications.^{11,13} This is not surprising as these traditional doctors lack the basic knowledge of physiology, anatomy, pathology, pharmacology and anaesthesia, which are necessary for the safe management of patients with gunshot injuries. Interestingly, these traditional doctors hardly ever refer patients even when there is obvious life threatening complications. Worse still, there are hardly any case of litigations against the traditional doctors when cases are mismanaged with obvious morbidity and mortality.

Our first patient had abdominal gunshot injury, which is an indication for a laparotomy to repair any injured organs. This is beyond the competence or comprehension of the tradomedical doctors, who think that the main consideration is to extract the pellets. In few instances, they are able to remove the very superficial pellets, albeit with crude methods and associated potential hazards, while in most cases, they are unable to extract the pellets. In the instant case, the traditional doctor was not able to extract the pellets, but deceived the

patient that the pellets have been removed by incantations. The pathology however progressed until the patient was forcefully removed from them and brought to us. At that stage however the patient was too ill to survive. This obviously was a case of avoidable death.

The second patient had a pneumothorax following gunshot injury. This was also beyond the competence of the traditional doctor who only thought of the removal of the pellets. The patient was brought to us early enough and responded favourably to orthodox medical treatment.

The third case had gunshot injury by low velocity pellets, which were lodged in the soft tissue. The traditional doctors knew nothing about anti-tetanus prophylaxis and use of antibiotics to prevent sepsis. They even made incision on the patient with unsterile blade without observing the necessary aseptic technique. It is not surprising therefore that the patient had tetanus.

The fourth patient had minor gunshot injury with the pellets embedded in the soft tissue. He was however deceived by the traditional doctor who told him that the pellets had been removed diabolically only for some of them to become palpable in the subcutaneous tissue few years later. There have been series of reports of cases of pellets that were said to have been removed by traditional doctors, only for X rays to reveal such pellets years after.

In conclusion the morbidity and mortality of gunshot injury management by the traditional doctors in Nigeria is quite high. This practice should be discouraged or regulated and people should be encouraged to resort to litigation wherever necessary. Some persons have advocated that the traditional doctors should be given some basic orthodox medical training as it is being done for traditional birth attendants in our community. But how safe this practice will be is another issue.

REFERENCES

1. Cummings P, Lemier M, Reek DB. Trends in firearm related injuries in Washington State 1989 – 1995. *Ann Emerg Med* 1998; 32: 37-43.

2. Goren S, Subasi M, Tirasci Y, Kemaloglu S. Firearm-related mortality: a review of four hundred – forty deaths in Diyarbakir, Turkey between 1966 – 2001. *Tohoku J Exp Med* 2003; 201: 139-45.
3. Bretsky PM, Blac DX, Phelps S, Ranson JA, Deguntis LC, Groce NE. Epidemiology of firearm mortality and injury estimates: state of Connecticut 1988 – 1993. *Ann Emerg Med.* 1996; 28: 176-82.
4. Morton R, Langley J. Firearm related deaths in New Zealand, 1978 – 1987. *NZ Med J* 1993, 106: 463-5.
5. Solagbem BA. Epidemiology and outcome of gunshot injuries in a civilian population in West Africa. *Eur J Trauma* 2003; 29: 92-6.
6. Adesanya AA, Afolabi IR, daRocha-Afodu JT. Civilian abdominal gunshot wounds in Lagos. *J R Coll Surg Edinb* 1998; 43: 230-4.
7. Yinusa W, Oginna MO. Extremity gunshot injuries in civilian practice: the National orthopaedic Hospital Igbobi experience. *West Afr J Med* 2000; 19: 312-16.
8. Onuba O. Management of civilian gunshot wounds in a Nigeria Hospital. *Arch Emerg Med* 1987; 4: 73-6.
9. Okonkwo JEN, Ngene O. Determinants of poor utilization of orthodox health facilities in a rural community. *Nigerian J Clin Practice* 2004; 7: 74 -8.
10. Thanni LO. Factors influencing patronage of traditional bone setters. *West Afr J Med* 2000; 19: 220-4.
11. Onuminya JE. Misadventure in traditional medicine practice: an unusual indication for limb amputation. *J Natl Med Assoc* 2005; 97: 824-5.
12. Ohanaka EC. Discharge against medical advice. *Trop Dolls* 2002; 32: 149-51.
13. Nwankwo OE, Katchy AU. Limb gangrene following treatment of limb injury by traditional bone setters (Tbs): a report of 15 consecutive cases. *Niger Postgrad Med J* 2005; 12: 57-60.