An Unusual Case Report on Co-Morbidity with Sexual Assault in the Mthatha Hospital, South Africa

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Abstract

Background: Comorbidity or the co-occurrence of mental disorders and substance abuse disorders is common among victims of sexual assault. Occasionally life-threatening conditions have been observed in these patients which need immediate medical attention.

Objective: To highlight the unusual case report of co-morbidity with sexual assault in a rural hospital in South Africa.

Case History: A seven-year-old girl was referred from a health center to a rural hospital with a history of sexual assault over four days by an unknown man. She was threatened to be killed in the case of disclosure. Her aunt suspected that she had a problem as she was not walking normally. Then she opened and described the whole incident. She was having a history of vaginal discharge with vomiting and diarrhea along with mild fever. She was also depressed. On physical examination, genital injuries including a ruptured hymen were confirmed. She was having muscle guarding of abdominal muscles. The victim was refused admittance as she was labeled a case of rape, but after persistent persuasion of the staff, she was admitted and later operated on for acute appendicitis. This case history, her physical examination, and the difficulty in getting admission to a surgical ward are discussed in this report.

Conclusion: Sexual assault may be associated with co-morbidity like acute appendicitis. Doctors must be vigilant in identifying such life-threatening co-morbidity to save the life of a patient.

Keywords*: sexual assault, abdominal pain, comorbidity*

Introduction

Co-morbidity or co-occurrence of disease conditions is not uncommon among victims of sexual assault, especially mental disorder and drug or alcohol abuse.[1] Sometimes there are some serious fatal conditions which need urgent medical or surgical attention which one cannot expect.[2]Getting diagnosis right is a key aspect of health care - it provides an explanation of a patient's health problem and informs subsequent health care decisions. The diagnostic process is a complex, collaborative activity that involves clinical reasoning and information gathering to determine a patient's health problem.[2]There is clearly a need to improve diagnosis in health care as diagnostic errors and inaccurate or delayed diagnoses persist throughout all settings of care and continue to harm an unacceptable number of patients.[2]

The victim of a rape feels pain from physical trauma in the aftermath of sexual assault, but there might be a micro biological complication as well caused by stress from the terrifying crime.[3]It is very important to recognise the early symptoms

of appendicitis, for example, so that one can seek medical treatment. Having ruptured appendicitis is a life-threatening situation. The risk of rupture rises dramatically after 48 hours of the onset of symptoms.[4]

It is likely that most people will experience at least one diagnostic error in their lifetime, sometimes with devastating consequences. Diagnostic errors may cause harm to patients by preventing or delaying appropriate treatment, and providing unnecessary or harmful treatment, or by resulting in psychological or financial repercussions.[2] The diagnosis is a collaborative effort. The stereotype single physician diagnosis is not true. The diagnosis process often involves intra-and inter-professional teamwork. Nor is diagnostic error always due to human error; often it occurs because of an error in system.[2] Child rape is becoming more common in South Africa. In 2000, over 52 550 cases of rape or attempted rape of women were reported to the South African police services. [5]Of these 21 438 victims were children under the age of 18 years.[5] Child rape increased to 24 387 in 2018/19 according to children institute of the University of Cape town.[6]

Tremendous challenges remain in the field of prevention of rape, especially in the former black homelands in South Africa. The history of South Africa sheds light on the factors behind the high incidence of rape in the country. Apartheid made violence an instrument of control and violence became the norm in people's day-to-day lives. There was rigorous apartheid in the black homelands. [7] Poverty is also a legacy of apartheid. This trio of poverty, sexual assault and HIV are complementary to one another.[7]Poverty forced people to use children for sexual exploitation.The purpose of this case report is to highlight the unusual co-morbidity of with sexual assault in a rural hospital in South Africa.

Case History

SR, a seven-year-old Grade 2 female child from Libode area, was brought to Centre with a history of sexual assault on 17 February 2006. An unknown man approached her while she was coming from school with her classmate. He was wearing dark glasses and driving a white car. The other child ran away, but the victim was caught and was promised to be given sweets and told she must not tell anybody. She was threatened to be stabbed if she disclosed. The man stripped and sexually assaulted her. The child did not tell as she was fearful of this man. Her aunt suspected she had a problem as she was not walking normally. When she asked child, she opened and told the entire story. The aunt found that she was having a discharge from a genital injury. There was also a history of vomiting and diarrhea of four days duration. She was also feverish, coughing, and depressed. The child was referred from the health center to the Sinawe Centre.

At the Sinawe Centre she was examined, and the finding was consistent with the history given by the victim. There were genital injuries with ruptured of hymen. Thorough investigations were ordered, and comprehensive management was carried out as per protocol. She was having muscle guarding of abdominal muscles, fever, and diarrhea and vomiting. The patient was also referred to a pediatrician at the Nelson Mandela Academic Hospital, but she was refused admittance as she was labelled a case of rape, but after persistent persuasion of the Sinawe staff, she was admitted and later operated on for acute appendicitis.

Discussion

This is an only case reported at one centre which is attached to a rural hospital. This centre caters for about 500 000 people in the region, and it provides services around the clock to all the victims of sexual assaults. It has trained nursing staff who are capable

of handling rape victims. They provide pre- and post-test counselling and give post-exposure prophylaxis to the victims. Delay in reporting is very common. This is because of lack of taxi fare or no transportation and sometimes it is because of threatening by the the perpetrator as in this case of SR. She reported after four days and, therefore, she lost the opportunity to get PEP, and is now vulnerable to get HIV infection.

SR was a victim of rape and at the same time suffered from acute abdomen pains. Rape victims are generally stigmatized not only in the eyes of laymen but also among health professionals. Doctors generally ignore it and shift the responsibility without taking a proper history and doing a physical examination. There is need to build a safer health care system so that victims of rape will not be neglected. It is difficult to establish whether SR got appendicitis because of the rape or if it is just a coincidence. After an extensive search of the literature, there was no evidence found that is suggestive of any association between rape and acute appendicitis. However, rigorous rape of a young child may induce the inflammatory process in the gut. SR received a serious genital injury as she could not even walk.

SR was refused admittance to hospital and returned to the one stop centre twice despite the note from a nursing staff member saying that it was a case of acute abdomen pain that needed surgical attention. Examination of the rape could have been carried out later but saving the life of the patient needed urgent attention. Anyhow, the doctor on duty examined and admitted her and subsequently operated for appendicitis. Unfortunately, doctor often just take the history of the rape and do not consider that there could be something else as well. A patient may have two or sometimes three acute conditions at the same time. Doctors must thus be vigilant regarding these associate conditions. A recently reported case of acute pancreatitis associated with severe acute respiratory distress syndrome in coronavirus-2 infection is an example of it.[8]SR was fortunate that she was diagnosed at the centre by the nursing staff. They felt that there was something else other than the genital injuries causing the lower abdominal pain. The health professionals are just carrying out genital examinations without looking for other morbid condition of victims. The completion of a J88 form or a rape crime kit is the only aim which is important to them. They must, instead, always examine a case of sexual assault holistically. The doctor is not just a genital technician and must not examine just the genitalia without assessing the patient thoroughly.

It is not clear how many patients are dying in rural hospitals because of errors of doctor. There is not much research carried out in this field, and nobody even discusses these issues in hospitals. It remains a secret of doctors and sometimes of nursing staff. Death certification is completely very poorly, and it is difficult assess the real cause of death. The cause of death is always a hidden affair known only to the treating doctor. If the cause is not clear, why do they write a fictitious cause of death on the death notification form? There are only two possibilities, either they were not able to diagnose the condition of the patient, or they hid it to avoid the litigation. In public hospitals there is no fear of individual doctor litigation. Patients may sue the hospital or health department. A study carried out the author in 2003 showed that doctors at hospitals are not experienced in completing a death certification form.[9] Most of doctors are certifying death as a cardiorespiratory failure, which is neither a cause of death nor a mechanism of death. In fact, it has no meaning.[9] Therefore, it is difficult to pick up any death which as caused by the negligence of a doctor. Very few cases were reported where the negligence of doctor was document and published by the author.

Reporting cases is also difficult as one doctor generally should not complain about another. Instead,

it is the management who must be vigilante. A case report by the author on inadvertent intrathecal administration of potassium chloride during routine spinal anesthesia was documented.[10] It had no impact on the services of the hospital. Several maternal deaths were also highlighted in this hospital because of it is mandatory to get an autopsy. A paper was published in the South African Medical Journal (2004) on maternal deaths, where doctors' serious negligence was reported,[11]but it just remained in the journal, and no action was taken by the hospital even though it is in the public domain. This is a dual tragedy in hospitals in this region of South Africa. Firstly, doctors are not skilled and sensitive to human beings and, secondly, there is very poor management of the hospital, lacking in managers who can function in the interests of patient care. Doctors must take responsibility for each death in hospital but unfortunately this does not happen. The management must develop a mechanism to ensure that the patient interest as priority. Weekly mortality meetings would be an important step to look at the cases so that the weaknesses in patient care could be discussed. It is sad that most of the time management is turning a blind eye to the problems of the hospital. Recently, some lawyers have shown an interest to ask for compensation from the health department in a few cases after whistle blowers have pointed out cases of neglect, but still there is not much change in behaviour in care of the patient.

Human errors are associated with the deaths of omission as well as commission. The act of omission deaths is difficult to recognise as there is hardly any proof but some of the deaths caused by act of commission may be picked up in a forensic pathology laboratory. There is not a reporting system in hospital at present for any possible cases of neglect. During the time of the previous Transkei government, there was a form which one had complete, but it is no longer in use. The only way to make a report is through publication in scientific journals but who will read these journals? Secondly, the individuals concerned remain anonymous so hardly anyone can be get punished. Ultimately the poor, illiterate and voice less patients are left to the mercy of God.

This rural hospitals in former Transkei region are situated in a very fascinating area in a mountains range with lush green fields. This region is historically known for its high crime rate, and hardly any white South African doctors are prepared to settle to work there. White South Africans were advantaged by the apartheid regimen and therefore they are skilled. They are not contributing to the development of rural hospitals in this region. There is a serious gap between those who have and those who have not. Similarly, this gap is also visible in the care of patients. There is a medical school but that is also staggering with a shortage of trained teachers. Therefore, adequate training of students and doctors is lacking. Government must organise some method so that those skilled in an urban setting can be available in rural hospitals as well.

Conclusion

Victims of sexual assault may be associated with co-morbidity. It could lead to or exaggerate or precipitate an acute appendicitis, although its mechanism is not clear. Therefore, rape victims must be examined holistically to avoid life threatening conditions.

Ethical Issue: The author has received ethical permission for a case report publication (approved project No. 4114/1999) from the Ethical Committee of the University of Transkei, South Africa. This report is kept anonymous as much as possible. However, if someone comes to be identified directly or indirectly, the author has no responsibility as his intention is to improve the patient care in this region, not to defame any hospital, region, or any individual.

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