

Case Report

Unusual Self Inflicted Injury in a Patient with SHAFT Syndrome

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The self-inflicted injuries are very common in depression. However, many of these patients exhibit other features, as well. The SHAFT syndrome describes a 'sad', 'hostile', 'angry', 'frustrated' and 'tenacious' individual who may present with varying degrees of self inflicted trauma.

We report a case with self inflicted trauma to the forearm following introduction of screws. This mode of injury in relation to SHAFT syndrome, to the best of our knowledge, hasn't been described in the literature before.

Case Report

A 24-year-old man was admitted with pain and swelling in the left forearm. He admitted introducing several long screws in his forearm, manually one by one, the previous night. The shafts of the screws were buried deep into the muscles of the forearm though their heads were still visible from the surface. This patient has been found to exhibit features of SHAFT syndrome on numerous occasions in the past. He appeared very restless and wanted prompt treatment. The old scars in his both forearm and wrists, according to him, were due to an accident in the past.

On examination, there was gross swelling in his non-dominant left forearm. This was associated with tenderness over the flexor muscles and erythema. The most prominent feature was the presence of several screw heads with inflammation, swelling and discharge at the sites of entry. The margins of entry wounds appeared ragged and big suggesting that the screws had been forcefully twisted through the skin. The pain was not disproportionate to the amount of trauma and the extensor surface of the forearm appeared normal and unaffected. There were also multiple scars, from previous injuries, present in a criss-cross manner in both forearms. The movements of the elbow and wrist were normal

on the affected side. There was no sensory or motor deficit and all peripheral pulses were palpable.

There was no evidence of any trauma in any other part of the body.

A radiological examination confirmed the presence of five screws lying haphazardly in the in the soft tissues of the upper two-thirds of the left forearm. The tip of one screw appeared very close to the proximal end of Radius but no bony injury or abnormality was detected.

A decision to remove the screws and debride the wounds under general anaesthetic was made and the patient informed. However, he declined to wait for an operation and, therefore pulled out all the screws himself, whilst in the Accident and Emergency Department. He, subsequently, self-discharged himself, dissatisfied and angry about the care he had received.

He was readmitted to the hospital two days later with marked features of cellulites in his left forearm. He also had pyrexia, pus discharge from the 'screw-entry points' and a raised white cell account. Again no evidence of compartment syndrome was detected. The treatment involved elevation, systematic antibiotics, anti-inflammatory drugs, regular dressings and close observation. A good response was seen and he was discharged few days later following improvement. However, during his stay he had remained very uncooperative and frequently demanded an operation for his condition. He required a lot of persuasion to continue his stay in the hospital.

Discussion

The management of the injuries in a patient with SHAFT syndrome is difficult. An injury in the non-dominant upper extremity should alert the physician to a possible factitious

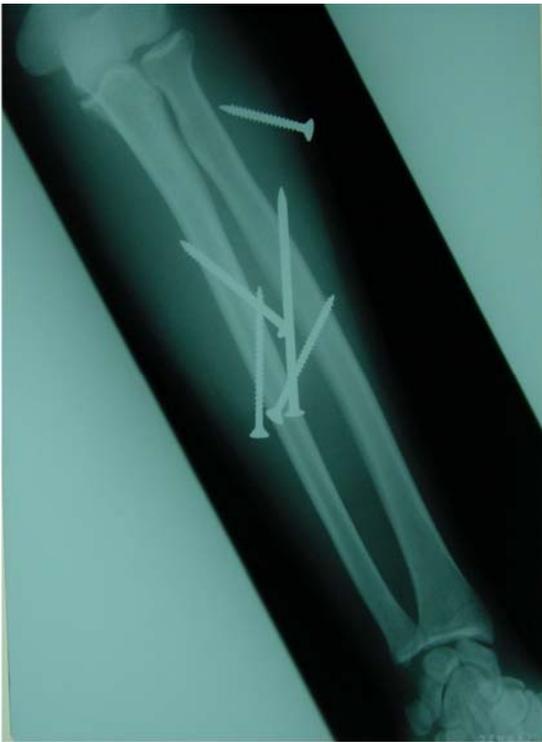


Figure 1. Xray AP view of the left forearm showing multiple screws embedded in the soft tissues as a result of self inflicted Injury in a patient with SHAFT Syndrome



Figure 2. Lateral view

pathology if the history about the cause is doubtful in such patients. Patients with SHAFT syndrome are overtly hostile and manifest anger about their situation. They inflict injuries on themselves, sometimes for a surgical adventure (Graham et al, 1999).

Features like hostility, aggressiveness, tenacity and a tendency to cause self-harm were present in our patient. Although, he left the hospital without treatment on his first visit, he did persistently ask for the surgical option at his next visit. The refusal to initial surgical treatment was probably directed by the compulsiveness for urgent or immediate treatment. The desire for surgical treatment did manifest at a later stage.

There is little evidence in literature of such a trauma caused by the introduction of screws in the forearm in SHAFT syndrome and other disorders involving factitious injuries. The probable cause of such an injury may be a compulsive idea that a major surgery might solve the problem or a failure to gain attention on previous occasions when injuries were minor.

In a study six out of 28 patients with factitious disorders, were found to be foreign body introducers (Al-Qattan, 2001). Several types of foreign bodies were used for inflicted such injuries. Out of these, small and sharp needles appear to be the commonest. However, the use of air, organic foreign body etc has also been described in relation to these injuries.

A thorough psychiatric assessment and treatment is necessary in all cases of factitious disorders as surgery alone is insufficient. The surgeon should give the opportunity to save face and must not deprive the patient of his defences that maintain his emotional integrity (Freidman et al, 1988).

The financial implications of treatment of self-inflicted injuries are serious. These are related to multiple operations and injuries, time-off work and long term-care (Kasdan & Stutts, 1995). Hence, an effective treatment of the psychiatric aspect of the illness is extremely important to minimise the incidence of self-inflicted injuries.

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