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The Pattern of Medico Legal Injuries Presenting at T.H.Q Hospital Ahmed Pur East.

[1] Dr. Baset Mahmood, [2]Dr.Abdul Rauf , [3]Dr. Sumaira abbasi, [4]Dr. Afzal Randhawa,

Abstract

Introduction

Casualty outdoor department is very essential part of hospital.each and every case of medical and surgical emergency first present and attended there.The first contact Doctor is the Casualty Medical officer (CMO) who examine and attend the patients coming to COD with different emergencies i.e accidents, Medico-Legal cases,poisoning cases, Burn and medical emergency cases like Hypertention,Myocardial Inforction ,gastroenteritis and severely detriorated Asthma patients

Objectives

1. To know the pattern of Medico-Legal Injuries at Secondary Care Hospital
2. To study the crime ratio in Rural Areas

Study Design

Retrospective Cross Sectional Study

Setting

T.H.Q Hospital Ahmad Pur East (Secondary Care Hospital)

Period

August 2016 TO November 2016

Material and Methods

Our study is record based Retrospective Study of MLC cases which were registered In MLC Register of T.H.Q Hospital Amed Pur East from August to November 2016. Data like Time of arrival, age and sex of registered cases, socio-economic status and type of weapon used for injuries, was collected from MLC register of COD this Hospital.The data was analyzed manually, presented in tables, by using variables, parameters and also compared with other studies

RESULTS

The percentage of Homicidal cases injuries was more (89.54%) and the predominat group was of males (81.36%) .Out of Homicidal injuries, we found that mainly Medico-Legal cases were registerd due to Assault leading to Skin deep (Lacerated) Head Injuries (38.18%), Bone fractured (29.34%) ,Teeth broken (6.8%) and joint (soulder,elbow) dislocations(5.9%) .The males were involved in 85% cases and maximum registered cases were from age group 21-30 yrs (35.90%). The most serious injuries were found in low socio-economic status people (61%) and average socio-economic status people (32.72%). The most serious injuries were found in low socio-economic status people (61%) and average socio-economic status people (32.72%).

Conclusions

The principal coclusion is that young age group people don't take care of their health and they quarrel with each other on small issues.The poor people are not properly educated and they live in rural areas mostly.They work in agricultural lands and give it too much importance.They even make issues on small marlas of land and start fighting with each other.Due to joint family system ,lot of families get disturbed and No. of

MLC cases increased.They use mostly wooden sticks and head injuries are more common in them.

Key Words

Medico-Legal cases, Casualty, Assault,Skin deep(laerated) wounds, Joint dislocations and Teeth broken.

Introduction

The Casualty Outdoor department(COD) is very essential and heart of the each Hospital.In COD ,all Medical and Surgical emergencies are reported here and first aid is given to patients.This is also the first Department of Secondary and Tertiary care Hospitals where Medico-Legal Cases are registered and Medico-Legal formalities are fulfilled.

In COD ,the first contact Doctor is ***Casualty Medical Officer(CMO)*** whose duty is to give First Aid, to save the lives of patients and registering MLC. The MLC may be a case of injury,Assault and illness.The ***CMO*** after listening and examining the Victum,gives opinion for any required investigation i.e xray, Expert opnion from Radiologist etc.Study of pattern of injuries is essential for treatment plan and study crime rate.In present study, attempt is made to study type of injuries, Age and sex of Registered cases, Time of arrival in COD, Weapon used for

SETTING

T.H.Q Hospital Ahmed Pur East

Aims & Objectives

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2. To study Crime ratio in Rural areas.

Materials and Methods

Our study is record based Retrospective Study of MLC cases which were registered In MLC Register of ***T.H.Q Hospital Amed Pur East from*** August to November 2016. Data like Time of arrival, age and sex of registered cases, socio-economic status and type of weapon used for injuries, was collected from MLC register of COD this Hospital.

The data was analyzed manually, presented in tables, by using variables, parameters and also compared with other studies

Inclusion Criteria

All MLC cases registerd from ***AUGUST TO NOVEMBER 2016*** in MLC Register of T.H.Q HOSPITAL Ahmed Pur East.

Exclusion Criteria

Received dead cases in COD.

OBSERVATIONS AND RESULTS

In our Four Months Retrospective Study from AUGUST TO NOVEMBER 2016, Total 220 MLC cases were reported and studied. Maximum MLC Cases were of Assault by Wooden sticks (58.63%), followed by Iron rods (22.27%) and

accidents (10.45%) . Minimum cases were of Firearm Injuries (8.63%) Table No.1,

In our study, according to age and sex wise distribution, the maximum cases were of Age Group 21-30 yrs old (35.90%), followed by 31-40 yrs (25%) and 11-20 yrs (16.36%) . Minimum MLC Cases were of Age Group 71-Above Age Groups (2.27%) Table No.2

Our study showed that Males were the predominant 183(83.18%) and females were 37 (16.81%) Table no.4 . Maximum no of MLC Cases were reported from 6AM TO 6 PM , 143(65%) then followed by 6 PM TO 12 AM 66(30%) and Minimum cases were reported from 12AM To 6AM 11(5%) Table No.3

In our study, the type of Injuries which were maximum reported, were of Head & Neck SKIN DEEP(Lacerated) injuries (38.18%) followed by Upper Limb Skin Deep (lacerated) injuries (24.09%) and Bruises/Abrasion (29.15%) . The minimum Skin Deep(Lacerated) injuries were in LOWER LIMB (09%) . The maximum Bone fractured was Humerus of Upper Limb (11.81%) , followed by Radius (7.72%) AND Shoulder joint Dislocation (5.90%) . The minimum Bone Fractured was Femur of Lower Limb (0.90%) . The Skin Deep(incised) wounds were maximum in Upper Limb (53%) , followed by Head & Neck (26%) and Upper Limb (9%) . The minimum Skin deep(Incised) wounds were in Thorax (03%) and Lower Limb (03%) Table No.4

AGE WISE DISTRIBUTION OF MLC CASES Table2

AGE	MLC CASES	PERCENTAGE %
0-10 YEARS	5	2.27%
11-20 YEARS	36	16.36%
21-30 YEARS	79	35.90%
31-40 YEARS	55	25%
41- 50 YEARS	21	9.54%
51-60 YEARS	11	5%
61-70 YEARS	8	3.63%
71-ABOVE	5	2.27%
TOTAL	22O	100%

SEX WISE DISTRIBUTION OF MLC CASES

GENDER	MLC CASES	PERCENTAGE%
MALE	173	83.18%
FEMALE	37	16.81%
TOTAL	220	100%

TIME OF ARRIVAL FOR REGISTERING MLC CASES Table No.3

TIME	MLC CASES	PERCENTAGE%
6AM TO 6PM	143	65%
6PM TO 12AM	66	30%
12AM TO 6AM	11	5%
TOTAL	220	100%

MANNER WISE DISTRIBUTION OF REGISTERED MLC CASES (Table No.6)

Manner	Male	%	Female	%
Accidental	17	7.72%	6	2.72%
Homicidal	179	81.36%	18	8.18%
Total	196	89.08%	24	10.90%
Total no of cases	196+24=220	Total %	89.08+10.90= 100%	

TYPE OF WEAPON USED IN HOMICIDAL MLC

CASES Table No.1

WEAPON USED	MLC CASES	PERCENTAGE
FIREARM	19	8.63%
IRON ROD,KASSI	49	22.27%
HARD WOODEN STICKS	129	58.63%
TOTAL	220	100%

SOCIO-ECONOMIC STATUS WISE DISTRIBUTION TABLE NO.7

Socio-economic status	*Mlc cases*	*%age*
Low socio-economic status	*135*	*61.37%*
Average soccio-economic status	*72*	*32.72%*
Upper socio-economic status	*13*	*5.90%*

SKIN DEEP	*MLC CASES*	*%AGE*
(i) LACERATED	*14*	*6.36%*
(ii) INCISED	*3*	*1.36%*
(iii) Bruise/Abrasion	*82/43*	*37%/19.54%*
(iv) Bone Factured (Ribs,Spine)	*23*	*10.45%*

HEAD & NECK INJURIES(TABLE NO.4)

HEAD AND NECK INJURIES(TABLE NO.4)

SKIN DEEP		MLC CASES	PERCENTAGE%
(i)	LACERATED	84	38.18%
(ii)	INCISED	26	11.81%
(iii)	BRUISE/ABRASION	65/28	29.54% /12.72%
(iv)	BONE FRACTURED (Nasal,Mandibl) Teeth	 18 15	 8.18% 6.81%

UPPER AND LOWER LIMBS (Table No.4)

SKIN DEEP		MLC CASES	PERCENTAGE%
(i)	Lacerated Uper limb Lower limb	 53 11	 24.09% 6.36%
(ii)	Incised Upper Limb Lower Limb	 9 3	 4.09% 1.36%
(iii)	Bruise/Abrasion Upper Limb Lower Limb	 62 /22 19 /5	 28.18% / 10% 8.63% / 2.27%
(iv)	BONE FRACTURED UpperLimb (Humerus,Radius,Ulna Phalanges,Scaphoid) Lower Limb (Femur, Patella, Tbia, Fibula, Foot bones)	 Humerus=26 Radius=17 Ulna=6 Phalanges=37 Scaphoid=5 Femur=2 Patella=4 Tbia=7 Fibula=6 Foot bones=5	 Humerus=11.81% Radius=7.72% Ulna=2.72% Phalanges=16.81% Scaphoid=2.27% Femur=0.90% Patella=1.81% Tbia=3.18% Fibula=2.72% Foot bones=2.27%

DISCUSSION

Our study showed that maximum registered MLC Cases were of Males (83.18%) and were in Age Group of 21-30 years old (35.90%) , followed by 31-40 years old (25%) and 11-20 years old (16.36%) , similar to Garg –V , Malik-Y, Marri-MZ and Hussain –SN Studies (1-2, 4, 6, 12) who are actively involved in work , agricultural & support activities and as a result , more injuries in this Age Group. The other fact which was noted, was

that mostly Males were Registered in MLC Cases (83.18%) and females

were (16.81%) as males are involved more in outdoor activities. The maximum MLC Cases were in reported from 9am to 6pm (65%) as most people are involved in their activities in day time. It is similar with studies of AUTHORS Yadav-A Singh, Dr Sv.Harridas and Bhullar DS. This shows that as day time progresses , Temp increases and people become frustrated. The other fact is that most people were coming from rural Areas to COD and these people involved in Agricultural activities. They fight on small issues of lands and they have joint families. They give too much importance to agricultural lands than their lives.

Conclusion

In COD , not only Medical and Surgical Emergencies are handled but also ,the CMO has responsibility to examine documentations and certify MLC Cases. Hence there is lot of burden on CMO due to dealing with such kind of problems. The CMO is also threatened from people coming for MLC Cases Registeration and he also remains under pressure of Political parties and Hospital Admenistration. The other issue is that the mostly appointed CMO are only MBBS degree Holder and initially appointed in COD who have no experience of MLC Cases and difficulties regarding Postmartum. This creates lot of disappointment and depression for newcoming Dr at SECONDARY CARE HOSPITALS. MBBS Drs should be trained during their housejob in COD of Tertiary CARE HOSPITALS. So that they can face the challenges of their upcoming life.

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