Homicidal Cut-Throat Injury: A Multidisciplinary Surgical Emergency – A Case Report

Ogah SA[1], Ashraff A[2], Muazu OM[2], Nwafor IP[3], Tamasanni SO[3], Obaro SY[3], Adaja GO[4]

ABSTRACT

Background: Cut-throat injuries, though relatively rare, are emerging more frequently due to the rising incidence of violent crimes such as terrorism and banditry. Cut-throat injuries pose significant management challenges, often requiring a multidisciplinary approach involving the anesthesiologist, otolaryngologist, and psychiatrist, especially in cases with suicidal intent. **Case Summary:** We present management of a case of an 18-year-old male with a homicidal cut-throat injury. Early presentation, prompt resuscitation, airway management via tracheostomy, and layered wound repair led to a successful outcome.

Key words: Cut-throat, injury, emergency.

[1]ENT Department Kogi State Specialist Hospital, Lokoja. [2]Shifaah Hospital. [3]Surgery Department, Kogi State Specialist Hospital, Lokoja. [4]Department of Anaesthesia, Federal Teaching Hospital, Lokoja.

Corresponding Author:

Dr. S.A. Ogah,
ENT Department, Kogi State Specialist Hospital,
Lokoja.Email: stephenogah@yahoo.com, Tel:
+2348147812454

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Introduction

Cut-throat injuries are acute surgical emergencies typically resulting from penetrating trauma to the anterior or lateral neck using sharp objects such as knives.[1] These injuries are life-threatening due to the presence of vital structures in the neck, including large blood vessels, the airway, esophagus, and cranial nerves, all of which are relatively unprotected.[2] Globally, the incidence of such injuries remains low; however, a rising trend has been observed, especially in regions affected by violent conflict.[3] Homicidal cut-throat injuries are more common than suicidal or accidental ones and usually present with sharply defined wound margins.[4] Suicidal wounds tend to be more ragged due to the "cut-and-stop" behavior associated with pain. Regardless of etiology, management must be prompt and multidisciplinary, aiming first to stabilize the airway and circulation.[5]

In this report, we present a case of a young Nigerian male with a homicidal cut-throat injury and describe the surgical and post-operative interventions that led to his recovery.

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Case Presentation

An 18-year-old male Nigerian, a 200-level Cybersecurity student at Confluence University of Science and Technology (CUSTECH), Osara, Kogi State, and a part-time Point of Sale (POS) operator, who sustained a homicidal cut-throat injury. He was attacked while accompanying a friend to conduct a business transaction. Before reaching their destination, his companion allegedly attacked him, attempting to poison him with a substance (suspected to be organophosphate) and subsequently inflicted a deep incised wound to his neck using a knife. The assailant stole his belongings and left him unconscious in a nearby bush along Zango Kabba Road, Nagazi, around 2:00 a.m.

He was discovered in a pool of blood by a local vigilante group and rushed to Shifaah Hospital at approximately 5:30 a.m. on December 24, 2024. Certainly, the 60 minutes 'golden hour' of a surgical and trauma care would have been exceeded at this time on arrival. He was actively bleeding from the neck wound. Resuscitation was initiated, and the otolaryngologist was consulted.

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The patient was taken to the operating theatre for emergency tracheostomy, wound exploration, and primary repair. Orotracheal intubation was performed by the anesthetist. A Ryle's tube was inserted for enteral feeding.

Under general anesthesia, the neck was extended with a shoulder roll and head ring. A tracheostomy was performed using a size 7.5 mm cuffed single-lumen tube (the only size available). Wound exploration revealed a laryngeal injury, which was repaired using 3/0 Prolene. Soft tissues were closed in layers with Vicryl 2/0, and the skin was closed using interrupted 3/0 nylon sutures. A rubber drain was inserted.

Postoperatively, the patient was managed on intravenous fluids (alternating normal saline and 5% dextrose water, 1 L every 8 hours), intravenous cefuroxime (750 mg every 8 hours), metronidazole (500 mg every 8 hours), and analgesics including paracetamol and diclofenac.

Tracheostomy tube suctioning was performed hourly or as needed. The cuff was deflated hourly to prevent tracheal pressure necrosis and permanently deflated after 24 hours.

Wound dressings were changed daily. The drain was removed on the first postoperative day. The patient tolerated tube feeding via the Ryle's tube.

On postoperative day 3, the tracheostomy tube became blocked; it was removed, cleaned, and reinserted. The single-lumen tube was replaced with double-lumen tube on postoperative day 7.

A dye test was performed on day 5 to rule out a pharyngo-cutaneous fistula. The patient was transitioned to para-tubal feeding with graded fluids and progressed to full oral feeding by day 7, at which point the Ryle's tube and all stitches were removed.

Tracheostomy decannulation began on day 10 using progressive gauze layering. The tube was finally removed, and the site was dressed. By day 14, wound granulation was observed, with inversion of skin edges. The wound was freshened and secondarily closed with 3/0 nylon sutures.

By postoperative day 17, the wound had healed satisfactorily, all stitches were removed, and the patient was discharged on oral medications with follow-up advice.

Discussion

Cut-throat injuries are increasingly seen in emergency departments in conflict-prone regions.[6] These injuries pose significant challenges due to the proximity of vital structures and potential for airway compromise, major hemorrhage, and long-term morbidity.[7-9] In this case, timely discovery and hospital presentation were crucial in achieving a favorable outcome.[10]

Key aspects of management include airway stabilization—often necessitating tracheostomy, control of hemorrhage, layered repair of the injury, prevention of infection, nutritional support, and monitoring for complications such as fistula formation or airway stenosis. Radiological imaging such as CT is considered the gold standard for assessing the extent of injury, but its utility must be weighed against clinical urgency and resource availability.[10]

Multidisciplinary management involving surgeons, anesthesiologists, and mental health professionals is critical, especially in suicidal cases.[10] In this homicidal case, surgical expertise and postoperative vigilance were central to the patient's recovery.[11]

Conclusion

Cut-throat injuries, though rare, are on the rise due to increasing violence and insecurity. Successful management relies on early presentation, prompt surgical intervention, and a well-coordinated multidisciplinary approach. Tracheostomy remains a vital tool, particularly in cases involving airway compromise, with double-lumen cuffed tubes preferred in the acute phase. Every otolaryngologist practicing in high-risk settings should ensure ready access to tracheostomy equipment. Outcomes are influenced by the extent of injury, timing of intervention, and the surgical expertise available.

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