

When the Bruise Doesn't Match the Bone: Clinical-Radiological Discrepancy in a Fabricated Forearm Injury

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ABSTRACT

Fabricated injuries, also known as feigned or self-inflicted injuries, are deliberately produced wounds created either by the individual themselves or with assistance, usually for deceptive medicolegal purposes such as false accusations, diversion of suspicion, sympathy seeking, or financial and legal gain. These injuries are typically inflicted on easily accessible and non-vital body parts to simulate assault, defensive injuries, strangulation, or sexual offences, while carefully avoiding serious harm. From a forensic standpoint, fabricated injuries present a significant challenge as they may closely resemble genuine traumatic wounds, necessitating meticulous correlation between history, clinical findings, and radiological evidence. We report a case of a 75-year-old male who presented to the emergency department of a tertiary care hospital alleging assault with multiple sharp and blunt weapons. Clinical examination revealed multiple injuries involving the upper limbs and right shoulder. The radiological evaluation demonstrated a healed fracture of the shaft of the left ulna with established callus formation at the site of the reported bruise, indicating that the fracture was more than three weeks old and temporally inconsistent with the alleged recent assault. The other injuries showed no radiological evidence of bony involvement. The marked discrepancy between the clinical presentation, radiological findings, and injury chronology raised suspicion of fabrication, particularly with respect to the left forearm injury. This case underscores the importance of integrating clinical examination with forensic radiology and maintaining awareness of characteristic fabrication patterns. Accurate identification of fabricated injuries is essential to prevent misuse of medicolegal systems and ensure fair judicial outcomes.

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INTRODUCTION

Fabricated wounds—whether self-inflicted or inflicted by another at the subject's behest—serve to escalate a criminal charge or manipulate legal outcomes. While sharp instruments are often used, blunt objects may also be employed, though less commonly due to the intense pain they inflict. Establishing fabrication requires scrutiny of wound characteristics, anatomical location, and their concordance with the alleged mechanism of injury.¹ Fabricated injuries are commonly seen on body parts that are easily accessible, such as the top of the head, forehead, neck, outer aspect of the left arm, front of the left forearm, front and outer aspects of the thighs, and the front of the abdomen and chest, to simulate defensive injuries, strangulation, rape, etc. The fabricator usually produces only as much injury as he thinks is necessary to support his story and is careful to avoid serious self-harm. Therefore, the injuries are typically multiple, superficial, and not situated on vital parts of the body.¹ Self-inflicted injuries, usually non-fatal unless complications arise, may be motivated by personal gain. The most common scenario is the fabrication of injuries to simulate an assault, either to divert attention from the person's own actions or to arouse sympathy. Fabricated accidental injuries are usually a form of malingering, such as in the armed forces, or fraudulent attempts to obtain

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compensation. In other cases, the “victim” may allege assault by a specific person, driven by motives of hatred or spite. Others may injure themselves and then waste police resources by insisting on a futile search for a non-existent assailant.²

From a forensic and medicolegal perspective, fabricated injuries constitute a significant challenge because they can closely mimic genuine accidental or assault-related injuries. Differentiation between true and fabricated wounds often requires meticulous evaluation of the history, clinical findings, and corroborative evidence, including scene examination, witness accounts, and forensic analysis.² Such injuries may display atypical patterns, unusual anatomical locations,

or inconsistencies with the alleged mechanism of trauma. Furthermore, fabricated injuries may be encountered in diverse contexts, including insurance fraud, interpersonal disputes, and legal proceedings involving false accusations.³

CASE REPORT

A 75-year-old man presented to the emergency department in the early hours, reporting assault by 5 to 6 persons with multiple weapons, including both sharp-edged weapons (dadar (a traditional sharp-edged agricultural implement), sword and axe) and a blunt weapon (baseball bat). The alleged incident occurred while he was in his fields. After obtaining informed consent, the patient was examined, and the following injuries were noted on the body of the patient:

- A reddish bruise, 4 x 3 cm, was present on the dorsal surface of the left forearm, 8 cm proximal to the left wrist and 15 cm distal to the left elbow. Pain and tenderness were present. An X-ray of the left forearm was advised. (Figures 1 and 2)
- A lacerated wound, 2.1 x 1.1 cm, was present obliquely on the outer side of the right forearm, situated 7 cm above the wrist and 16 cm below the right elbow. Fresh bleeding was present. Pain and tenderness were present. An X-ray of the right forearm was advised.
- An incised wound, 2.1 x 0.5 cm, was present obliquely on the front of the right hand, situated 6 cm above the tip of the thumb and 5 cm distal to the right wrist. Fresh bleeding was present. Fresh bleeding was present. An X-ray of the right hand was advised.
- A reddish bruise, 2.1 cm x 1.1 cm, was present on the top



Figure 1: Clinical photograph showing a reddish bruise on the dorsal surface of the left forearm.



Figure 2: X-ray of left forearm showing healed shaft fracture of ulna with callus formation.

of the right shoulder. Pain and tenderness were present. There was a restriction of movement involving the right shoulder. An X-ray of the right shoulder was advised.

The opinion regarding the nature of injuries was reserved pending receipt of the X-ray films/report. The radiological examination of the X-ray films revealed a fracture of the shaft of the left ulna (corresponding to site of injury No 1), characterised by rounding of fracture margins and the presence of callus formation, radiologically suggestive of a fracture older than three weeks, a finding inconsistent with the estimated age of Injury No 1. Injuries Nos. 2, 3, and 4 revealed no radiological evidence of bony injury. All the injuries related to the present incident were declared simple in nature. The fracture at the site of injury No. 1 was old and unrelated to the present incident, hence excluded from the current MLC opinion.

DISCUSSION

This case raises suspicion of a fabricated injury, particularly due to the mismatch between bruise and fracture timelines. Forensic literature describes several indicators suggestive of fabricated injuries:

- Discrepancies between clinical history and physical findings, such as a mismatch between weapon description and wound pattern or injury.^{3,4}
- Superficial, parallel, or patterned lesions on easily accessible, non-vital body parts.²
- Differences in the age of different injuries.²
- Absence of defensive injuries or clothing damage, which undermines assault claims.^{3,4}

Many studies from our country reinforce this observation: fabricated gunshot wounds have been reported to often appear on non-vital areas and are self-inflicted or assisted.

Similarly, healed callus-bearing fractures with inconsistent timelines reflect a fabrication pattern. Scientific analyses highlight the critical role of careful history-taking, proper injury documentation, and clinical photography; simple tools (e.g., a hand lens) help in distinguishing assault from fabrication.⁵⁻⁷ Further supporting this, case reports of self-inflicted gunshot wounds simulating criminal harm demonstrate that even seemingly convincing wound patterns can ultimately be identified as self-inflicted upon thorough investigation. A rare case of a young woman with a gunshot wound to the hand was reported in which the injury pattern closely mimicked an assault. Although the near-contact entry wound, extensive soft-tissue damage, and stellate exit wound were initially consistent with a defensive injury, the patient later admitted to self-infliction using an 8-mm blank pistol. This case demonstrated that self-inflicted injuries may convincingly simulate criminal offences even when atypical features such as firearm use and defence-like wounds are present.⁸ Fourteen cases of self-inflicted injuries created to simulate criminal offences have been described by Karger B *et al.*⁹ While most cases demonstrated typical features of self-infliction—such as superficial wounds, anterior localisation, parallel injury patterns, and sparing of highly pain-sensitive areas—many also exhibited atypical findings. These included large limb hematomas, gaping incised wounds, lip injuries, eyelid hematomas, cerebral concussion, extensive burns, and evidence of restraint. Consequently, the presence of unusual or severe injuries, whether alone or alongside typical patterns, does not rule out self-infliction. In most instances, the alleged victims did not initially report the incident themselves; reports were often made by individuals whose sympathy or attention was being sought. Although psychopathological factors were the predominant motivation, rational incentives such as attempted insurance fraud were also identified.

In this case, the temporal mismatch coupled with the nature and location of the bruise—absent of defensive indicators and inconsistent with the alleged assault—suggest fabrication. The healed ulna fracture indicates a prior injury, whereas the fresh bruise was likely superimposed to exaggerate the assault claim.⁹⁻¹³

CONCLUSION

Fabricated injuries continue to pose a significant medicolegal challenge, requiring a cautious and evidence-based approach to interpretation. Accurate differentiation between genuine and fabricated trauma necessitates meticulous documentation and careful correlation of clinical findings with imaging and injury chronology. This case highlights how radiological evidence can unmask critical discrepancies between the alleged history and objective findings, thereby raising suspicion of possible fabrication. The presence of a healed fracture inconsistent

with the timing of the reported assault underscores the importance of integrating forensic radiology into routine medicolegal evaluation. Such an approach not only aids in identifying inconsistencies but also helps prevent misuse of medicolegal systems and ensures fair and just outcomes in legal proceedings.^[14-17]

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