

SEXUAL ABUSE

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Sexual abuse is the exploitation or involvement of a child in sexual activities. Sexual activities include, but are not limited to, exposure, fondling, genital contact, or pornography. Statutory rape criteria vary somewhat from state to state, and include both age of the child (often less than 14 years), difference in age between participants (usually three to four years), and capacity of the child to consent in situations of same age sexual activity.

I. Statistics. The prevalence of sexual abuse is difficult to determine because much remains undiagnosed. In addition, studies investigating prevalence and incidence have varying definitions of what constitutes abuse. In 1997, there were more than 100,000 substantiated reports of sexual abuse in the United States, which represented 12% of all child maltreatment victims. Sexual abuse has been diagnosed in children of all ages, races, and socioeconomic groups. The perpetrator is often a male family member, family friend, or neighbor who has access to the child or has authority over the child.

II. Presentation. Children may present to their primary care providers because of behavioral or physical symptoms, or because of recent disclosure of abuse by the child or a sibling of abuse. If a report has been made to the children's protective services (CPS), a CPS social worker may ask to have the child examined as part of an investigation. While many sexually abused children have no symptoms, others may act out sexual behaviors, experience sleep disturbances, develop phobias, perform poorly in school or regress in their behavior. Abused children may complain of genital-rectal symptoms, such as pain, itching, redness, discharge, or bleeding.

Sexual abuse should be considered in all children presenting with secondary enuresis, encopresis, or other genitourinary complaints. Lice in eyelashes should prompt an investigation of sexual abuse, as only pubic lice infest the eyelashes.

III. History. The purpose of the interview is to collect information that may validate the history of abuse, to determine what testing needs to be done, and to begin the healing process for the child. Children who have been previously interviewed about the alleged abuse should not be re-questioned about the same issues by the physician.

The history should be obtained in a calm, relaxed and accepting manner. Before referring to body parts, the physician should ask the child or caregiver what words she/he uses when referring to the genitalia and rectum. Anatomical dolls or drawings should not be used without specific training, as they may provide a source of leading information and render the interview invalid. The physician should encourage the child to tell the story him/herself using open ended, non-leading questions, e.g. "tell me what happened" not "who hurt you?". During the interview it is helpful to tell the child that disclosing the abuse was the right thing to do and that you will try to prevent the abuse from happening again. If the alleged perpetrator is a family member or a close friend, the child's parents may have difficulty believing that the abuse occurred. When parental support is absent, children often recant because of family pressures.

The history should be thoroughly documented in the child's chart. All historic statements should be attributed to the person who made them, i.e. "per the mother, the child was..." and statements made by the child should be delineated with quotation marks.

IV. Forensic Evidence:

- A. In most states, if the last sexual assault occurred less than 72 hours ago **and** the nature of the assault suggests that seminal fluid, pubic hair, saliva or blood belonging to the perpetrator might be recovered from the patient's body or clothing, then forensic specimen collection is required. The physician should refer the patient immediately to an emergency facility or similar site capable of forensic evidence collection. Instruct the patient not to bathe or change clothes prior to the examination. Advise the family to bring a change of clothes, as the garments the child is wearing may be kept as evidence. If the child has changed clothes, advise caregivers to bring the garments in a PAPER bag.
- B. If there is no possibility of forensic material being present and no acute injury is suspected, the physical examination can be scheduled for a convenient time and place. Children with acute injuries or symptoms should be examined urgently to evaluate and document injury and need for treatment.

V. Examination. The purpose of the examination is to look for supporting evidence of sexual abuse, screen for sexually transmitted diseases (STDs) and reassure the child that his/her body is, or will be, "*fine*." Physical findings of acute trauma should be documented. A colposcope is the best tool to capture photodocumentation of genital and rectal injury. When no colposcope is available, a 35mm or digital camera may be used. Exams are best done by professionals trained in sexual abuse evaluations. When this is not possible, positive findings should be confirmed and followed up by an experienced examiner.

A. Preparation. Prior to the exam, comfort the child by discussing examination positions. Some examiners demonstrate positions using a doll. When time allows, have the child practice correct positioning while still clothed. Permit the child to have control about who stays with him/her during the exam. Assure the child that the examination will not be painful.

B. Technique - Examination Positions

1. **Frog leg.** Position the child in a supine position with her knees out and soles together, knees resting on the exam table. The child can lie on an examination table or sit on his/her parent's lap, whichever seems most comfortable.
2. **Knee-chest.** Have the child get on all fours, with knees spread wider than shoulders. Then have the child touch his/her chest to the exam table, maintaining the knee placement with a swayed backbone. Use a drape while adjusting the child's position. The knee-chest position is particularly useful to visualize vaginal foreign bodies and the posterior hymenal rim.

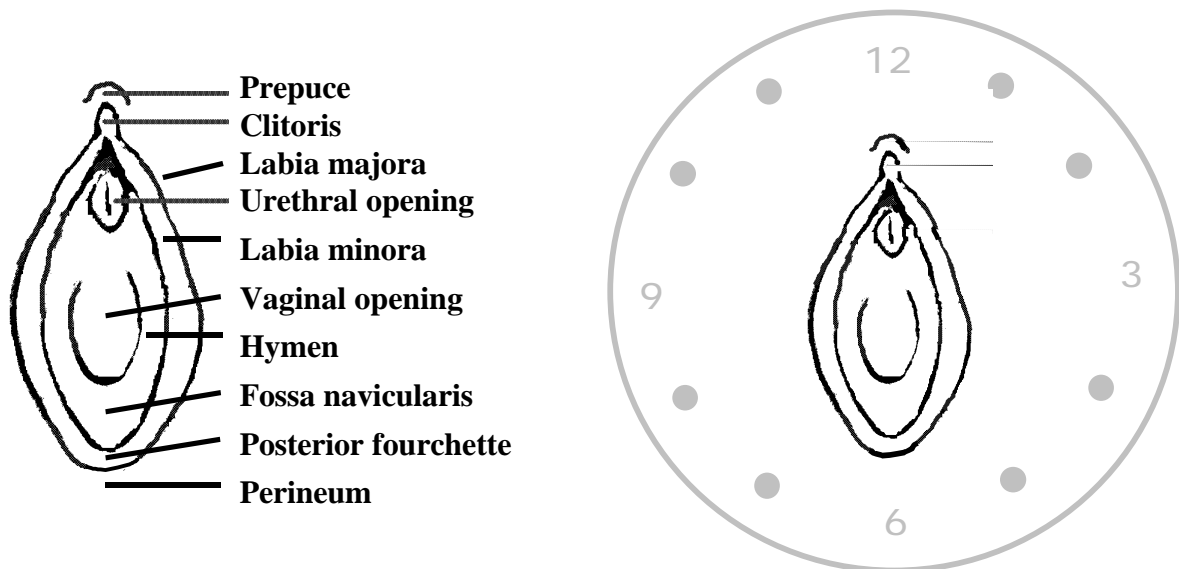
C. Technique – Examination

Examine the external genitalia for signs of injury and infection. Examine the perineum for injuries, condylomata, herpetic lesions, bruises, tears or discharge. A vaginal speculum is contraindicated in almost all pre-pubertal examinations. Visualize the hymen by holding onto the labia majora with the thumb and forefinger of each hand and retracting them outward (toward the examiner), laterally and downward toward the rectum. When done properly, the introitus will open and the inner hymeneal ring will be visible. Examine the hymen for signs of trauma.

The delicate non-estrogenized hymen is very sensitive, and may fold onto itself making the hymenal rim difficult to visualize. "Floating" the rim using a syringe of warmed saline is a painless aid to visualization, particularly in the knee-chest position.

D. Findings – Genitalia

Figure 1. Prepubertal Female Anatomy



- 1. Prepubertal female.** When documenting, refer to location of findings using a “clock face” orientation, with the urethra at 12 o’clock and midline posterior fourchette at 6 o’clock. Girls less than two, as well as older girls after puberty may have redundant, estrogenized hymenal tissue with bumps or tags. A non-estrogenized hymen is often crescent shaped with little or no tissue between 10 and 2 o’clock, and may have bumps or tags. Other normal findings include labial adhesions, ridges inside the vagina, and bands between the labia minora and urethra. Clefts or defects of the hymen may indicate injury, particularly when found in the posterior rim between 5 and 7 o’clock. Absent hymen between 3 and 9 o’clock probably indicates changes from previous injury. An enlarged hymeneal opening without signs of trauma should not be considered indicative of vaginal penetration.

Fewer than 10% of abused prepubertal girls will have clear evidence for sexual abuse on genital examination, 15% will have findings that are suspicious or suggestive but not diagnostic of abuse, 50% will have nonspecific findings and 30% will have normal genital examinations. The likelihood of significant physical findings increases if the child provides a history of bleeding and when the examination is conducted soon after the alleged abuse

- 2. Pubertal female:** Inspect the external genitalia for acute injury, condylomata, herpes and lice. Perform, if possible, an internal speculum and bi-manual examination and obtain routine cultures for STDs. Findings suggestive of hymeneal injury can be easily confused with the normal adolescent hymenal anatomy of redundant folds and notching.
- 3. Male.** Inspect the genitalia for infection or injury.

B. Findings - Rectum. Examine the rectum for trauma, including scars, bruising or tears. Normal or non-specific findings include: anal tags, thick or smooth skin in the midline, anal gaping with stool in the rectal vault, flattened or thickened anal folds, fissures, and delayed venous congestion of the perianal tissues. Immediate anal dilatation ≥ 15 millimeters without stool in the rectal vault is suspicious. A deep peri-anal laceration extending beyond the external anal sphincter is an indication of penetrating trauma.

VI. STD Testing. The algorithm below will assist in deciding when to culture for STDs. Cultures are only necessary for symptomatic males, or when the perpetrator is documented to have an STD. In the presence of condyloma, rectal cultures for gonorrhea and chlamydia and blood testing for syphilis and HIV should be considered. When obtaining *N. gonorrhoea* (GC) and chlamydia cultures in pre-pubertal girls, sample the mucosa just proximal or distal to the hymen with a moistened Type I Calgiswab. In pubertal females, sample the cervix. Presumptive positive gonococcal cultures on Thayer-Martin media must be confirmed by at least 2 confirmatory tests (biochemical, enzyme substrate or serologic). Only GC and Chlamydia cultures should be accepted as evidence of infection in prepubertal children. Rapid tests, including DNA amplification, are currently inadequate for legal documentation.

VII. Treatment. Prepubertal children do not require prophylactic antimicrobial treatment for GC or chlamydia unless infection is thought to be likely. Gonorrhea vaginitis is usually symptomatic in prepubertal girls. Adolescents should be offered STD prophylaxis, and, if the assault was within 72 hours, pregnancy prophylaxis.

VIII. STD Prophylaxis

Trichomoniasis, bacterial vaginosis, chlamydia and gonorrhea are the most frequently diagnosed infections among adolescents who have been sexually assaulted. Hepatitis B infection can be prevented by post-exposure administration of hepatitis B vaccine, and should be considered for adolescents who have not received the vaccine. Prophylaxis guidelines are published periodically by the Centers for Disease Control (CDC) in the Morbidity and Mortality Weekly Report. Current updates appear on their website. The CDC recommends a follow-up examination for adolescents two weeks after the assault.

Treatment includes:

Cefixime 400 mg PO x 1 **or** Ceftriaxone 125 mg IM x1

or

Spectinomycin 40 mg/kg IM x 1 (max. 2g) for PCN allergic patients

and

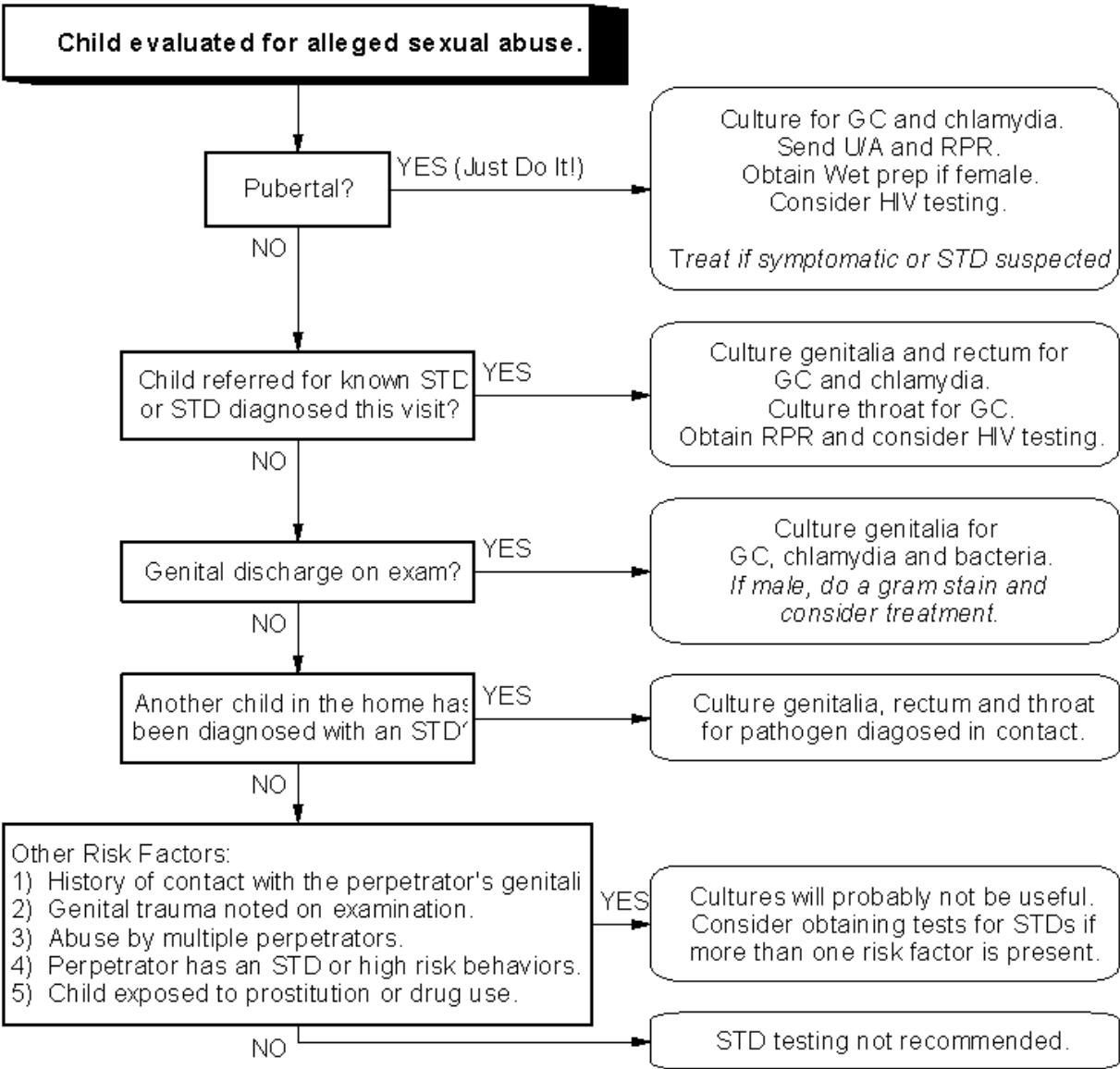
Azithromycin 1g PO x 1, **or** Doxycycline 100 mg PO BID x 7 days (if ≥ 9 y/o)

and

Metronidazole 2 grams PO x 1

IX. Pregnancy Prophylaxis. Prophylaxis against pregnancy should be offered in all cases of sexual assault which may result in pregnancy. Prophylaxis consists of two Ovral tablets within 72 hours of the assault, followed by two additional tablets 12 hours after the first. Consider Benadryl 25 – 50 mg $\frac{1}{2}$ hour prior to administering Ovral to prevent nausea.

X. Reporting. All states require physicians to report suspected sexual abuse.



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www.calib.com/NCCANCH/ - national clearinghouse on child abuse and neglect

<http://wonder.cdc.gov/wonder/prevguid/p0000480/entire.htm#head019000000000000> - specific updated recommendations for evaluation and treatment of sexual assault victims