Child Sexual Abuse
We’ll Discuss

• What Medical Providers (don’t) Know
• Guidelines for Medical Care
• Classification of Medical Findings
• Differentiating a Medical History from a Forensic Interview that has been Characterized as a Medical History
• What does the Medical Diagnosis of Sexual Abuse Mean
What Medical Providers (don’t) Know
Abnormal Becomes NL
Makoroff, Shapiro CAN 26: 1235

• 46 prepubertal girls have non-acute genital exam called abnormal by ER docs
• 32 (70%) were normal when examined by doc experienced in child abuse
• 8 (17%) showed clear evidence for abuse
• 4 (9%) findings were non-specific
• 2 (4%) had findings seen more often in SA but not diagnostic for SA
WHY?

- Lack of experience and training
- Changing interpretation of findings
- Tendency to overcall
- Do not want to miss abuse

- Surveyed 129 primary care physicians
- % Incorrectly identified structures:
  - hymen 41%
  - labia majora 39%
  - labia minora 24%
  - urethra 22%
  - clitoris 11%
Lentsch KA, Johnson CF. Do physicians have adequate knowledge of child sexual abuse? The results of surveys of practicing physicians.

*Child Maltreatment.* 2000;5:72-78

Surveyed 166 primary care physicians

- % Incorrectly identified structures:
  - hymen 38%
  - labia majora 21%
  - labia minora 17%
  - urethra 28%
  - clitoris 6%
• Guidelines for Medical Care of Children Who May Have Been Sexually Abused

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I. The Medical Evaluation:

• All children who are suspected victims of child sexual abuse should be offered a medical evaluation. The timing and detail of the examination should be based on specific screening criteria developed by qualified medical providers.
The goals of the medical evaluation are:

• To obtain the history from the child and/or guardian
• To consider alternative explanations for a concerning sign or symptom
• To identify and document evidence of abuse
• To diagnose and treat medical conditions resulting from abuse
• To diagnose and treat other medical problems
• To assess the health consequences
Goals......

• To assess the child’s safety
• To reassure the child and family
• To obtain or refer for counseling if indicated
• To document findings in such a way that information can be effectively and accurately presented in legal settings, if required
• To help to ensure the well being of the child
The Medical History:

- Any medical evaluation for suspected child sexual abuse should involve obtaining a medical history for the purpose of diagnosis and treatment.
- While there is no clearly superior model for obtaining history, there are certain principles and competencies that must be acknowledged.
Documentation

• Any statements made by the child to the healthcare provider must be recorded in detail, since careful documentation has the potential to obviate the need for multiple interviews.

• The goal is to make a transparent record of the entire evaluation.
Physical Exam Documentation

• As with the medical history, physical examination findings must be carefully and thoroughly documented in the medical record. Photographic still and/or video documentation of examination findings is strongly encouraged, and is particularly important if the examination findings are thought to be abnormal.
Classification of Findings
Guidelines for Medical Care for Children who may have been Sexually Abused

Summary

- Findings documented in newborns, or commonly seen in non-abused children.
  - Normal variants (Newborn study, non-abused studies by McCann et al, Berenson et al, Myhre et al, Heger et al, and various textbooks)
  - Findings commonly caused by other medical conditions – formerly called non-specific findings (Non-abused studies, textbooks, case reports of conditions mistaken for abuse)
Findings documented in newborns or commonly seen in non-abused children:

• **Normal variants**
  • 1. Periurethral or vestibular bands
  • 2. Intravaginal ridges or columns
  • 3. Hymenal bumps or mounds
  • 4. Hymenal tags or septal remnants
  • 5. Linea vestibularis (midline avascular area)
  • 6. Hymenal notch/cleft in the anterior (superior) half of the hymenal rim
Findings documented in newborns or commonly seen in non-abused children:

- 7. Shallow/superficial notch or cleft in inferior rim of hymen (below 3 o’clock - 9 o’clock line)
- 8. External hymenal ridge
- 9. Congenital variants in appearance of hymen, including: crescentic, annular, redundant, septate\(^3,4\), cribiform, microperforate, imperforate
- 10. Diastasisani (smooth area)
- 11. Perianal skin tag
Diastasis Ani
Findings documented in newborns or commonly seen in non-abused children:

12. Hyperpigmentation of the skin of labia minora or perianal tissues in children of color, such as Mexican-American and African-American children \(^8,9\)

13. Dilation of the urethral opening with application of labial traction \(^2,3\)

14. “Thickened hymen” (May be due to estrogen effect, folded edge of hymen, swelling from infection, or swelling from trauma. The latter is difficult to assess unless follow-up examination is done) \(^2,3,12,13\)
Findings documented in newborns or commonly seen in non-abused children:

Findings commonly caused by other medical conditions:

15. Erythema (redness) of vestibule, penis, scrotum, or peri-anal tissues (may be due to irritants, infection or trauma)

16. Increased vascularity (dilatation of existing blood vessels of vestibule and hymen possess irritant or not)

17. Labial adhesion. (may be due to irritation or rubbing)

18. Vaginal discharge (many infectious and non-infectious causes, Must culture to confirm STD)
Vulvovaginitis in Children

• Vulvitis is more common than vaginitis
• Vaginitis is redness and discharge from the vaginal mucosa
• Causes in prepubertal children include viruses, helminths, bacteria and other non-venereal causes
Vulvovaginitis in Children

- **Non-venereal causes:**
  - accidental foreign bodies
  - chemical irritation
  - mechanical irritation
  - allergy
  - trauma
  - lichen sclerosis
  - ectopic ureter
  - rectovaginal fistula
Vulvovaginitis in Children

• Viral causes:
  – chicken pox
  – Molluscum contagiosum

• Heminths:
  – enterobias vermicularis (pinworm)
  – ascaris lumbricoides (round worm)
  – trichuris trichura (whipworm)
Vulvovaginitis in Children

• **Bacterial causes:**
  – strep. pyrogenes (GABHS)
  – h. Influenza, non-typable
  – strep. Pneumonia
  – shigella Sonnei
  – bacteroides spp.
  – E. coli
  – klebsiella Pneumonia
  – corynebacterium spp.
Group A Strep Vaginitis
“Vaginitis”

- Study from *Pediatrics*, 1999:
  - 93 girls less than age 12 with “vaginitis”
  - 21% had a microbiologic cause
    » GC = 4.6%
    » Aerobic bacteria = 17%
    » Yeast = 2.7%

- “Vaginosis” resolves as quickly with or without antibiotics (yogurt and good hygiene).
- Test for STD’s if symptoms persist
- DO NOT put on antibiotics until culture confirmed!!!
Findings documented in newborns or commonly seen in non-abused children:

• 19. Friability of the post fourchette or commisure (may be due irritation, infection or traction of exam)
• 20. Excoriations/bleeding/vascular lesions can be due to lichen sclerosus, eczema or seborrhea, vaginal/ perianal Gp A Strep, urethral prolapse, hemangioma
• 21. Perineal groove (failure of midline fusion) partial
• 22. Anal fissures (poss due to constipation/irritation)
• 23. Venous congestion or venous pooling in peri-anal area (usually due to exam or constipation)
Findings documented in newborns or commonly seen in non-abused children:

• 24. Flattened anal folds – May be due to relaxation of external sphincter or to swelling of perianal tissues due to infection or trauma

• 25. Partial or complete anal dilatation to less than 2 cm A/P diameter, with or without stool visible (may be a normal reflex or other cause severe constipation or encopresis, sedation, anesthesia, neuromuscular condition)
Indeterminate Findings: Insufficient or conflicting data from research studies: (May require additional studies/evaluation to determine significance) These physical/laboratory findings may support a clear disclosure but should be interpreted cautiously if the child gives no disclosure

- Physical Examination Findings

- Lesions with etiology confirmed: (Condyloma and Herpes) Indeterminate specificity for sexual transmission
Physical Examination Findings

26 Deep notches or clefts in the posterior/inferior rim of hymen in pre-pubertal girls, located between 4 and 8 o’clock, in contrast to transections.

27 Deep notches or complete clefts in adolescents at 3 or 9 o’clock

28 Smooth, non-interrupted rim of hymen between 4 and 8 o’clock which appears to be less than 1 mm wide in prone knee/chest position or using water to float the hymen when in supine position
Physical Examination Findings

29 Wart-like lesions in genital or anal area (Biopsy and viral typing may be indicated if appearance is not typical of Condyloma accuminata)

30 Vesicular lesions or ulcers in the genital or anal area (viral and/or bacterial cultures or nucleic acid amplification tests may be needed for diagnosis)

31 Marked, immediate anal dilation to an A/P diameter of 2 cm or more in the absence of other predisposing factors
INDETERMINATE

Lesions with etiology confirmed: Indeterminate specificity for sexual transmission (Report to CP per AAP Guidelines unless perinatal or horizontal transmission is likely)

32  Genital or anal Condyloma accuminata in child in absence of other indicators of abuse

33  Herpes Type 1 or 2 in the genital or anal area in a child with no other indicators of sexual abuse
• **Findings Diagnostic of Trauma and/or Sexual Contact.** The following findings support a disclosure of Sexual Abuse and are highly suggestive of abuse even in the absence of a disclosure unless a clear, timely, plausible description of accidental injury is provided by child/caretaker

  – Acute trauma to external genital/anal tissues

  – Residual (healing) injuries
• Injuries indicative of blunt force penetrating trauma (or from abdominal or pelvic compression injury if such history is given, ie: run over by an automobile)

• Presence of infection confirms mucosal contact with infected and infective bodily secretions, contact most likely to have been sexual in nature.

• Diagnostic of sexual contact (pregnancy and sperm)
Acute trauma to external genital/anal tissues

34 Acute lacerations or extensive bruising of labia, penis, scrotum, peri-anal tissues, or perineum (May be from unwitnessed accidental trauma or physical/sexual abuse)

35 Fresh laceration of posterior fourchette, not involving hymen (Must be differentiated from dehisced labial adhesions or failure of midline fusion, or from accidental injury or consensual sexual intercourse in adolescents)
Impaled on handle of recliner
Residual (healing) injuries

These findings are difficult to assess unless an acute injury was previously documented at the same location.

36 Peri-anal scar (Rare, may be due to other medical conditions such as Crohn’s Disease, accidental injuries, or previous medical procedures).

37 Scar of posterior fourchette or fossa (Pale areas in the midline may also be due to lineavestibularis or labial adhesions).
Injuries indicative of blunt force penetrating trauma (or from abdominal/pelvic compression injury if such history is given)

38 Laceration (tear, partial or complete) of the hymen, acute
39 Ecchymosis (bruising) on the hymen (in the absence of a known infectious process or coagulopathy)
40 Peri-anal lacerations extending deep to the external anal sphincter (not to be confused with partial failure of midline fusion)
Injuries indicative of blunt force penetrating trauma (or from abdominal/pelvic compression injury)

41 Hymenal transection (healed). An area between 4 and 8 o’clock on the rim where it appears to have been torn through to or nearly to the base so no hymenal tissue remains at that location. (must confirm with swab, knee/chest, Foley or float the edge. Called a complete cleft in sexually active

42 Missing segment of hymenal tissue. Area in the posterior/inferior half of hymen wider than a transection, extends to base. Confirm using additional position methods as described above
Punctate hole thru base of hymen in same infant
Completely normal 4m later
Presence of infection

43  Positive confirmed culture for gonorrhea, from genital area, anus, throat, in a child outside the neonatal period
44  Confirmed diagnosis of syphilis, if perinatal transmission is ruled out
45  Trichomonas vaginalis infection in a child older than 1yr with organism identified by culture or in vaginal secretions by wet mounts by experienced technician or clinician.
46  Positive culture from genital or anal tissues for Chlamydia, if child is older than 3yrs by cell culture or CDC approved
47  Positive serology for HIV, if perinatal transmission, transmission from blood products and needle contamination has been ruled out.\textsuperscript{18, 19}
Diagnostic of sexual contact

48  Pregnancy\textsuperscript{19}

49  Sperm identified in specimens taken directly from a child’s body\textsuperscript{*}

\textsuperscript{*} Not all that looks like sperm is sperm
Medical vs. Forensic History

**Medical History**
- HPI
  - What happened
  - Pain/Bleeding?
  - Exposure to STI’s
  - Possible Pregnancy
  - Any resultant symptoms
  - Other possible victims
- PMH
- FH
- SH
- ROS

**Forensic History**
- Basically charge elements that go beyond medical care issues like:
  - In what room did it happen
  - Which jurisdiction
THE MEANING OF A NORMAL EXAM
Medical Diagnosis

• Made for the purpose of treatment
• In the vast majority of cases diagnosis is made based on child's history
  – Analogous to abdominal pain
• When there are no physical findings, should have no legal relevance
  – Beware of “consistent with...”
• Medical providers have no scientific tools to tell fact from fiction
Summary

• When positive physical findings are reported, always have them reviewed by an objective expert.
• When an STI is used as proof, always review with an objective expert.
• If the medical history seems excessive (read testimonial) get a medical opinion.
• A diagnosis based on history should not be admissible without clear physical findings.