Anal Findings in Suspected Child Sexual Abuse
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Disclosures
• I have no relevant financial interests

Objectives
• Recognize examination techniques
• Recognize normal anatomy
• List pathology/non-abuse
  • Congenital
  • Systemic disease
• Recognize trauma findings
• Analyze documentation issues

Supine Technique
• Useful for prepubertal children and adolescents
• Patient can see examiner
• Not always optimal for relaxation of gluteal area
• Patient can “hold knees” for improved visualization

Lateral Decubitus
• Position of comfort
• Patient can assist by holding onto knees
• Position commonly used for rectal examination

Standing
• Could be a position of comfort for patient
• Legs should be spread and back bent forward

Prone Knee Chest
• May be uncomfortable due to head down position
• May cause fear and anxiety
• View of rectum and vaginal area may be better than other positions
• Reflex dilation may be more apparent if position is held too long
Normal Anatomy


Anal Position Index
Others have created tables showing measurements of distance from anus specific anatomical points.

Anteriorly displaced anus or ectopic anus has been described.

**Congenital Findings**
- Linea Vestibularis
- Diastasis Ani
- Anteriorly displaced anus
- Skin Tags
- Failure of Midline Fusion

**Diastasis Ani**
- Smooth tissue due to underlying reduced support tissue—described as wedge shaped smooth areas either anterior or posterior to the anus

**Differential Diagnosis of Tags**
- Normal
- Human Papilloma Virus
- Molluscum Contagiosum
- Langerhans cell Histiocytosis
- Perianal Verrucous epidermal nevus
- Crohn’s Disease or other IBD
- Perianal Lymphangioma circumscripturn

**Physiologic Findings**
- Venous Pooling and Congestion
- Hyperpigmented perianal area
- Hemorrhoids
Causes of Anal Dilatation
• Neurologic disorders
  • Congenital myotonic dystrophy
• Sedative effects
• Stool and physiologic
• Sexual Abuse
• Death

Anal Manifestations of Systemic Disease
• Crohn’s Disease
• Rectal Prolapse
• Constipation
• Hemorrhoids
• Herpes Zoster

Fissures and Scars
• Study of three groups: A. Physically abused; B. Sexually abused and denied anal penetration and C. Sexually abused with rectal penetration.

Table 3  Fissures and scars

<table>
<thead>
<tr>
<th>Groups (n)</th>
<th>Fissures</th>
<th>Scars</th>
<th>Fissures + scars</th>
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</thead>
<tbody>
<tr>
<td>A (81)</td>
<td>2</td>
<td>0</td>
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</tr>
<tr>
<td>Physical (56)</td>
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<td>0</td>
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<tr>
<td>Accident (11)</td>
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<td>Medical (9)</td>
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<tr>
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<tr>
<td>B (83)</td>
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<td>3</td>
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<tr>
<td>C (50)</td>
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<td>16</td>
<td>3</td>
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<tr>
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<td>4</td>
<td>3</td>
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<tr>
<td>Not proven (37)</td>
<td>18</td>
<td>13</td>
<td>1</td>
</tr>
</tbody>
</table>

Pierce A. Anal fissures and anal scars in anal abuse—are they significant? Pediatr Surg Internatl. 2004; 20:334-338
Differential Diagnosis of Anal Fissures
• Constipation
• Pinworms
• Lichen Sclerosis
• Eczema
• Diaper rash

Differential Diagnosis of Perianal Erythema
• Group A Streptococcal infection
• Other infection (Herpes or Varicella)
• Diaper rash
• Pinworms
• Other dermatologic pruritic disease
• Trauma

Anal Findings Associated with Trauma
• Tears
• Fissures
• Bleeding
• Perianal bruises

Documentation Issues
• Know the anatomy
• Document the position
• Use clock numbers
• Drawing as well as photo

Summary—Key Points
• Non pathologic findings such as tags and dilatation may be caused by or confused with non-acute abuse
• Infectious processes and inflammatory diseases may need to be ruled out
• Documentation and photographs are critical