Solving a Mystery of Child Sexual Abuse: The Roles of the Clinician and CPS

ANN S. BOTASH, MD
DIRECTOR, CARE
PROFESSOR OF PEDIATRICS

OBJECTIVES

- Explain why all children suspected of being sexually abused need a skilled medical examination
- Describe appropriate medical management of a child sexual abuse case
- Explain the best way to document a child sexual abuse case

CASE

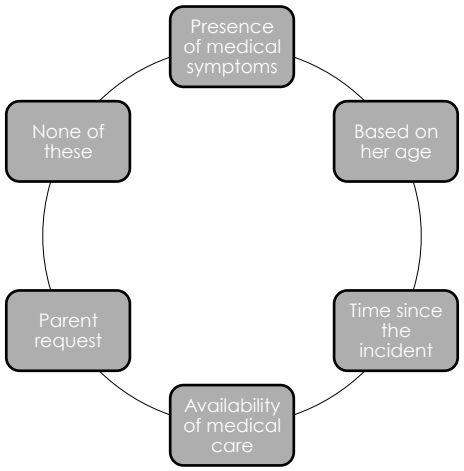
- A 6 year old prepubertal girl was left in the care of her grandfather. He has a history of abusing his daughter.
- The last time was 2 weeks ago and she has not been sleeping well and has started to have behavioral problems at school.
- Her mother became concerned because she noticed staining in the girl's underwear and thought it might be blood.
- She denies any sexual abuse.

EXECUTIVE DECISION MAKING SYSTEM

DOES SHE NEED A MEDICAL EVALUATION?

WHAT DO YOU THINK?

How did you make this decision?



THE ANSWER IS….

- None of these.
- She needs an examination!

REASONS TO DO AN EXAMINATION

- To reassure the child and family that the child is healthy
- To assess the medical needs of the child and to treat injuries, infections, and/or provide prophylaxis
- To assess and address emotional, social, mental health, and developmental needs of the child and family and provide crises intervention
- To refer for medical, mental health, or social issues
- To assess safety and intervene to prevent further abuse

REASONS TO DO AN EXAMINATION

- To decrease the likelihood of child's recantation by enhancing parental support and awareness
- To capture spontaneous disclosures
- To potentially increase the likelihood of perpetrator confession
- To document evaluation findings
- To collect forensic evidence

WHAT DO WE DO FIRST?

First, take your own pulse…

HANDOUT

Sexual Abuse Evaluations

What to do when sexual abuse is suspected in a pre-pubertal child.

Pre-pubertal children may present with a history of inappropriate touch to the genital area by another person. Complaints may range from genital discomfort, fondling, oral/genital contact or genital/genital contact.

History

Complete history, including:

- ___ Caregiver concerns related to sexual abuse
- ___ Disclosures from child
- ___ Behavioral concerns
- ___ Reported perpetrator (child, adult, relative)
- ___ Type of contact by reported perpetrator
- ___ Date / time of last possible contact by perpetrator

Do not discard clothing or clean patient if forensic evidence collection is planned.

Physical

Complete physical examination, especially:

- ___ Inspection of all body parts and thorough skin exam
- ___ Oral examination (lip, tongue, buccal) to look for frenula tears, palatal petechiae, or dental injuries
- ___ Complete genital examination to look for signs of acute injury or other abnormalities

Consults

- ___ Hospital Social Work
- ___ Gynecology consult if acute vaginal bleeding and possible need for ELVA
- ___ Surgery consult if significant rectal bleeding and potential for rectal perforation
- ___ Call Vera House, 422-7273, for both SANE (Sexual Assault Nurse Examiner) and Advocacy services

Diagnostic tests

Routine tests:

- ___ Dirty catch urine specimen or vaginal gen-probe for GC and Chlamydia
- ___ Cultures for STI's – GC and Chlamydia cultures for anal specimens and a GC culture for pharyngeal specimen

Consider:

- ___ CBC with platelets, LFTs, CMP Hepatitis B surface antibody and surface antigen, Hepatitis C antibody, HIV, and an RPR or VDRL
- ___ Forensic Evidence Kit per SANE consult if last contact within 96 hours
- ___ Stool guaiac for occult blood
- ___ Urinalysis and urine culture if symptoms also consistent with UTI

Medications

Consider:

- ___ HIV post-exposure prophylaxis if genital to genital contact within 36 hours or if acute injuries are present whether or not consistent with history

For more Testing and Treatment information: http://www.champprogram.com/pdf/Testing-and-Treatment.pdf

Documentation

- ___ History obtained, from whom and to whom
- ___ Physical findings with drawings and measurements
- ___ Tests ordered and performed and results
- ___ Consults requested (Social Work, CPS, SANE)
- ___ Documentation of genital findings
- ___ For females, document hymenal configuration, presence or lack of cuts, tears, abrasions, ecchymotic areas, visible discharge, or bleeding.

Avoid using term "hymen intact."

- ___ Use of photographic documentation by SANE
- ___ Impression: suspected sexual abuse

Do not document "No evidence of sexual abuse."

Reporting

Call Child Protective Services Hotline 1-800-635-1522 to make a report.

- ___ Ask them to check if there are other children in the home. They should be evaluated by either their PMD or the CARE Program.
- ___ Ask for a scene investigation, if necessary.

As a licensed professional, you are required to report suspected abuse. A referral to the CARE Program is not the same as a Hotline report to Child Protective Services.

At discharge from the ED or hospital

- ___ Refer patient to the CARE Program. Call 464-2273 (464-CARE).
- ___ Refer patient to the Pediatric Infectious Disease office, 464-6331, if appropriate for follow-up of HIV test results and/or HIV PEP.

Contact the CARE Program (464-2273) for a consultation with board certified child abuse pediatricians

Ann S. Botash, MD • Alicia Pekarsky, MD

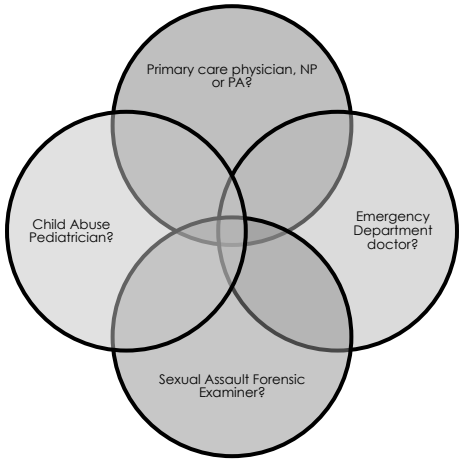
CARE Program | UPSTATE Golisano Children's Hospital

DOES THIS CHILD NEED TO BE SEEN IMMEDIATELY?

http:// childabusemd.com/ triage/triage-overview.shtml

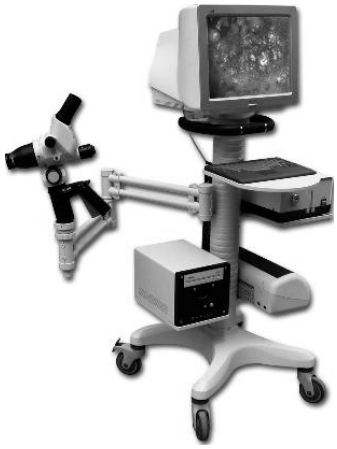
http://www.champprogram.com/pdf/07-0402-Triage.pdf

WHO SHOULD EVALUATE THIS CHILD?



SANE

- Model program for pediatric sexual abuse forensic evidence collection.
- Nurses work within practice parameters to examine, photograph and document history and findings.
- Reduces need for repeat examinations.
- Improves legal outcomes, medical treatment and possibly also psychological outcomes.



SANE

•Forensic evidence need must be considered early on and weighed with acute medical needs.

•History, Exam, Treatment, Documentation and Interpretation (Diagnosis) is still the role of the physician.

THINGS TO CONSIDER

- Forensic evidence in cases of significant physical abuse
- Order of exam/collection of specimens for culture and for evidence
- Even if >96 hours, might consider SANE for cases where there are findings

Things to Consider

- Sensitivity of tests for semen
- Studies that suggest >24 hours collection in children is not helpful used microscopic identification of semen (one also used P30 but not standard)
- These studies did not look at collection of saliva or sweat nor test using DNA
- Clothing, linens may be more likely to harbor evidence (anyway)

HISTORY

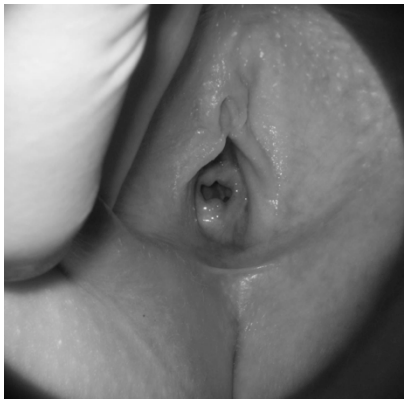
Complete history, including:

- Caregiver concerns related to sexual abuse
- Disclosures from child
- Behavioral concerns
- Reported perpetrator (child, adult, relative)
- Type of contact by reported perpetrator
- Date / time of last possible contact by perpetrator

Do not discard clothing or clean patient if forensic evidence collection is planned.

http://childabusemd.com/history/history-overview.shtml

The 6 year old



- The last exposure was 2 weeks ago.
- Possible blood in her underwear.
- Behavioral concerns

What were the behaviors?

- Use of sexual language
- Masturbation in public
- Inserting objects into genitals

What is normal behavior?

TABLE 1 Examples of Sexual Behaviors in Children 2 to 6 Years of Age

Normal, Common Behaviors	Less Common Normal Behaviors[a]	Uncommon Behaviors in Normal Children[b]	Rarely Normal[c]
• Touching/masturbating genitals in public/private	• Rubbing body against others	• Asking peer/adult to engage in specific sexual act(s)	• Any sexual behaviors that involve children who are 4 or more years apart
• Viewing/touching peer or new sibling genitals	• Trying to insert tongue in mouth while kissing	• Inserting objects into genitals	• A variety of sexual behaviors displayed on a daily basis
• Showing genitals to peers	• Touching peer/adult genitals	• Explicitly imitating intercourse	• Sexual behavior that results in emotional distress or physical pain
• Standing/sitting too close	• Crude mimicking of movements associated with sexual acts	• Touching animal genitals	• Sexual behaviors associated with other physically aggressive behavior
• Trying to view peer/adult nudity	• Sexual behaviors that are occasionally, but persistently, disruptive to others	• Sexual behaviors that are frequently disruptive to others	• Sexual behaviors that involve coercion
• Behaviors are transient, few, and distractable	• Behaviors are transient and moderately responsive to distraction	• Behaviors are persistent and resistant to parental distraction	• Behaviors are persistent and child becomes angry if distracted

[a] Assessment of situational factors (family nudity, child care, new sibling, etc) contributing to behavior is recommended.
[b] Assessment of situational factors and family characteristics (violence, abuse, neglect) is recommended.
[c] Assessment of all family and environmental factors and report to child protective services is recommended.

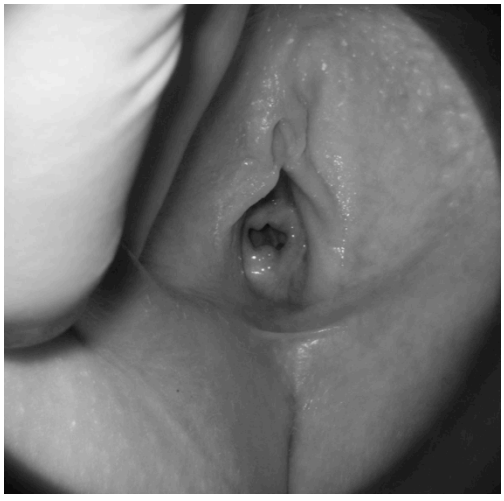
Kellogg, ND. AAP 2009

HISTORY OF GENITAL BLEEDING

- Trauma to genital area
- Rectal tears from constipation
- Urinary tract pathology or infection
- Genital tract disease pathology (infections, tumors, other)
- Skin Conditions
- Poor hygiene
- More complete differential:

http://childabusemd.com/diagnosis/diagnosis-abuse.shtml#genital

HOW IS THE PHYSICAL EXAMINATION PERFORMED?

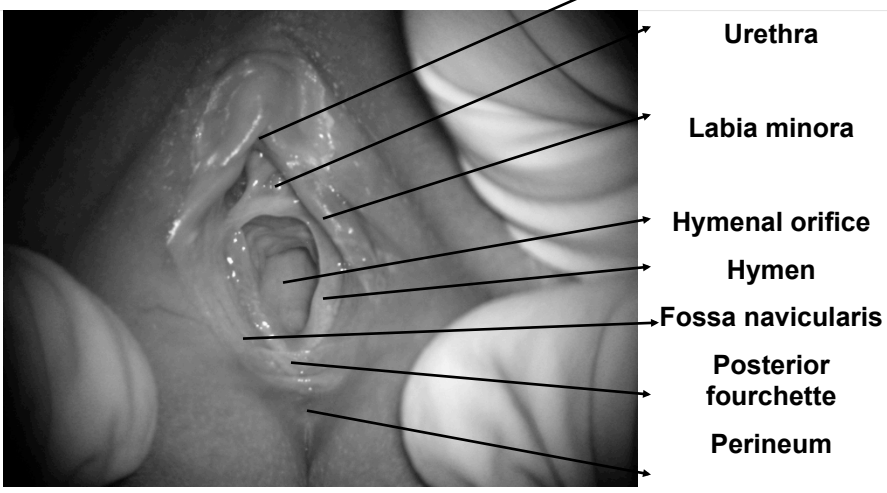


Physical

Complete physical examination, especially:

- Inspection of all body parts and thorough skin exam
- Oral examination (lip, tongue, buccal) to look for frenula tears, palatal petechiae, or dental injuries
- Complete genital examination to look for signs of acute injury or other abnormalities

NORMAL ANATOMY

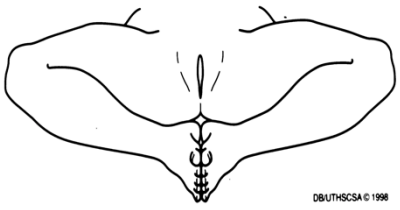


EXAMINATION TECHNIQUES

Supine Frog-leg position
Knee chest position
Standing
Lateral Decubitus
Labial traction vs. Spreading

Supine Technique

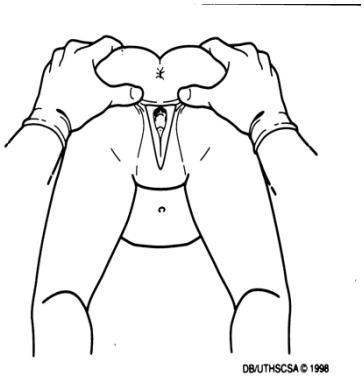
- Useful for prepubertal children and adolescents
- Patient can see examiner
- Not always optimal for relaxation of gluteal area
- Patient can "hold knees" for improved visualization



Reference: McCann JJ, Kerns DL.*The Anatomy of Child and Adolescent Sexual Abuse: A CD-ROM Atlas/Reference.* 1999; www.intercorpinc.com

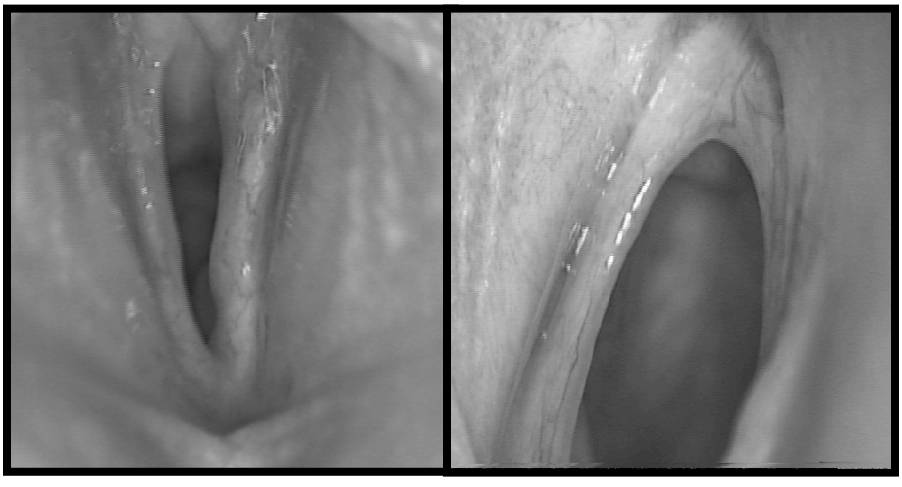
Prone Knee Chest

- 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



Reference: McCann JJ, Kerns DL.*The Anatomy of Child and Adolescent Sexual Abuse: A CD-ROM Atlas/Reference.* 1999; www.intercorpinc.com

Supine *Knee/Chest*



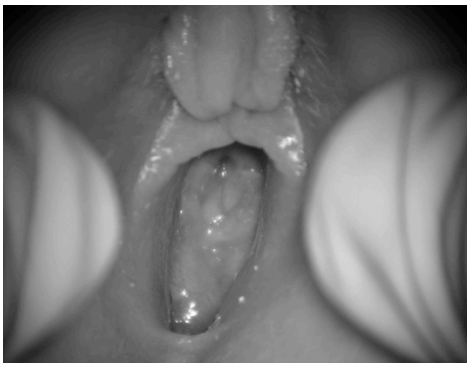
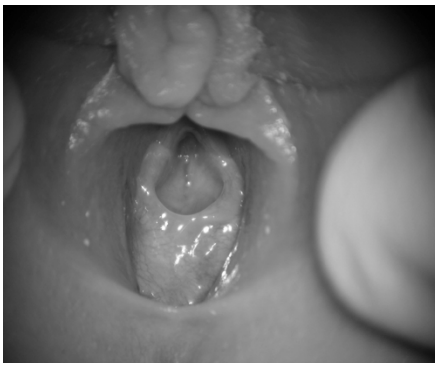
Standing

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

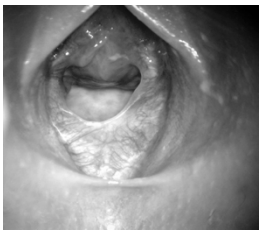
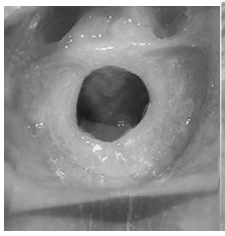
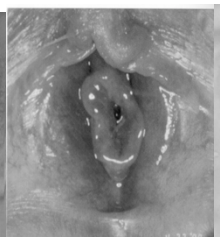
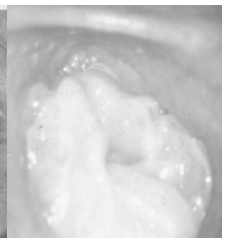
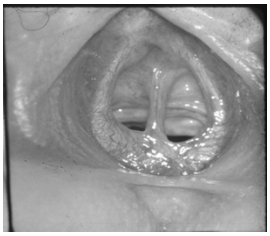
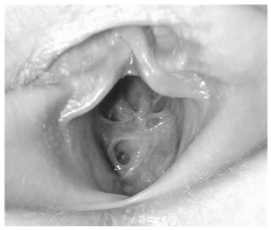
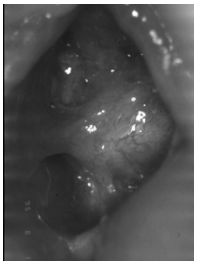
Lateral Decubitus

- Position of comfort
- Patient can assist by holding onto knees
- Position commonly used for rectal examination

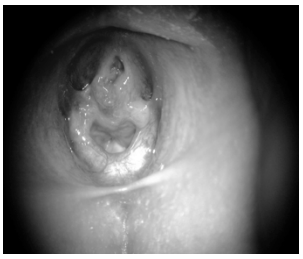
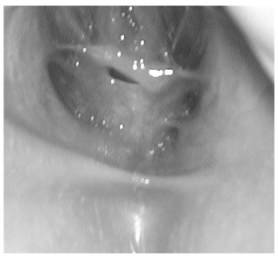
LABIAL TRACTION

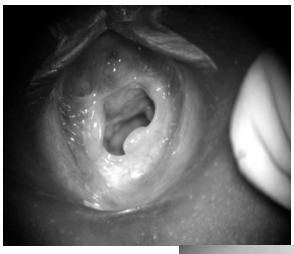
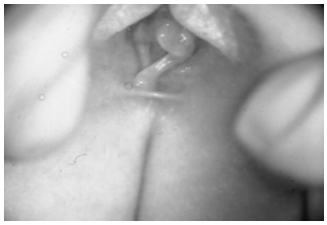
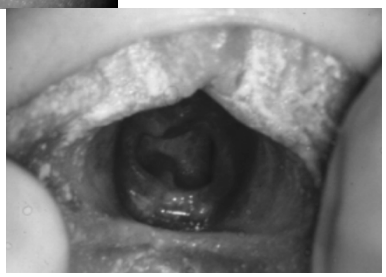
Hymenal Configurations

Peri-hymenal and Peri-urethral bands

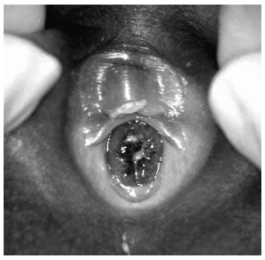



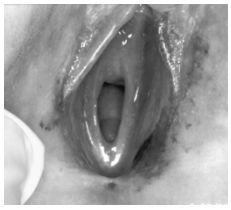
Bumps/Mounds/Tags

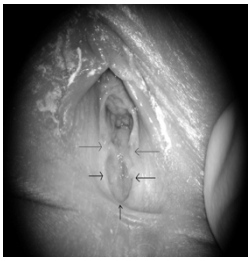




CONSULTS

- Hospital Social Work
- Gynecology consult if acute vaginal bleeding and possible need for EUA
- Surgery consult if significant rectal bleeding and potential for rectal perforation
- Dermatology Consult
- SANE (Sexual Assault Nurse Examiner) and Advocacy services
- Psych consult





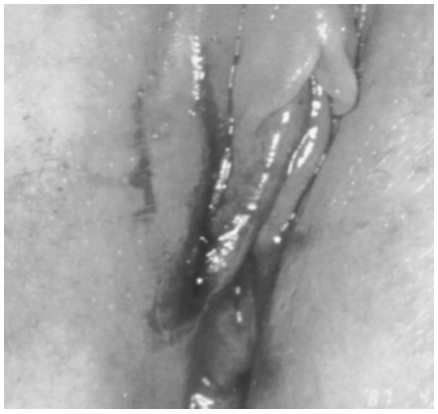


MIMICS

URETHRAL PROLAPSE, LICHEN SCLEROSIS AND FAILURE OF MIDLINE FUSION CAN BE CONFUSED WITH SIGNS OF GENITAL TRUAMA

STRADDLE INJURY

This is a common cause of bleeding after accidental trauma to the perineum. A good history should uncover this diagnosis.



DIAGNOSTIC TESTS

Routine tests:

- Dirty catch urine specimen or vaginal gen-probe for GC and Chlamydia
- Cultures for STI's – GC and Chlamydia cultures for anal specimens and a GC culture for pharyngeal specimen

TESTING AND TREATMENT

Medical Care	Hours				Weeks		Months					
	24	48	96	120	1	2	1	2	3	4	6	12
1 Acute & Follow-up Examinations					Follow-up Exam 1 to 2 weeks		Exams for physical and emotional well-being may be done at any time.					
2 Forensic Specimen Collection												
3 HIV Post-Exposure Prophylaxis & Testing	36 hours						Re-test 4-6 weeks		Re-test 3 months		Re-test 6 months	
4 Pregnancy Testing & Prevention	72 hours				Follow-up Serum ßhCG 1 to 2 weeks							
5 STI Testing					Follow-up cultures 1-2 weeks		RPR, HBV 4-6 weeks		RPR, HBV, HCV 3 months		HCV 6 months	
6 STI Treatment					Treatment may be offered in the acute post-assault setting. Treatment decisions are guided by results of diagnostic testing.							
7 Drug Facilitated Sexual Assault Testing												

http://www.champprogram.com/pdf/Testing-and-Treatment.pdf

COCAN GUIDELINES: AAP

Pediatrics 2005 116;506-512
Adapted for 2006 CDC STD Treatment Guidelines: MMWR 55 (No. RR-11):1-100, 2006.

TABLE 6. Implications of commonly encountered sexually transmitted (ST) or sexually associated (SA) infections for diagnosis and reporting of sexual abuse among infants and prepubertal children

ST/SA Confirmed	Evidence for sexual abuse	Suggested action
Gonorrhea*	Diagnostic†	Report§
Syphilis*	Diagnostic	Report§
Human immunodeficiency virus¶	Diagnostic	Report§
*Chlamydia trachomatis**	Diagnostic†	Report§
Trichomonas vaginalis	Highly suspicious	Report§
Condylomata acuminata (anogenital warts)*	Suspicious	Report§
Genital herpes*	Suspicious	Report§**
Bacterial vaginosis	Inconclusive	Medical follow-up

Adapted from: Kellogg N, American Academy of Pediatrics Committee on Child Abuse and Neglect. The evaluation of sexual abuse in children. Pediatrics 2005;116:506–12.

* If not likely to be perinatally acquired and rare nonsexual vertical transmission is excluded.
† Although culture is the gold standard, current studies are investigating the use of nucleic acid amplification tests as an alternative diagnostic method.
§ Report to the agency mandated to receive reports of suspected child abuse.
¶ If not likely to be acquired perinatally or through transfusion.
** Unless a clear history of autoinoculation is evident.

NAATS

- NAATs (SDA, TMA) and use of noninvasive specimens (urine) can be used for detection of C. *trachomatis* in prepubertal girls ***if positives can be confirmed.***
- None of the available NAATs are approved for rectal specimens, will still need to do culture.
- NAATs may not offer a significant advantage over culture for detection of GC.
- Positives should be confirmed by culture or repeat NAAT using a different method.

WHEN WE MIGHT CONSIDER NAATS

- If patient uncooperative or young,
  - Urine NAAT
    - First void best (NOT clean catch)
  - If urine positive, confirm with culture, or at minimum, second urine NAAT

Palusci V, Reeves. Ped Infec Dis J 2003. Jul;22(7): 618-23.

- If suspicion for infection exists with negative culture (esp Chlamydia).
- Follow up can be assured.

DIAGNOSTIC TESTS

Consider:

- CBC with platelets, LFTs, CMP Hepatitis B surface antibody and surface antigen, Hepatitis C antibody, HIV, and an RPR or VDRL
- Forensic Evidence Kit per SANE consult if last contact within 96 hours
- Stool guaiac for occult blood
- Urinalysis and urine culture if symptoms also consistent with UTI

DOCUMENTATION

- History obtained, from whom and to whom
- Physical findings with drawings and measurements
- Tests ordered and performed and results
- Impression: suspected abuse, physical exam consistent with the history…

  Do not attempt to further interpret findings if there will be a child abuse consultation.
- Impact statement to be faxed to CPS or police

INTERPRETATION OF FINDINGS

Adams JA. Guidelines for medical care of children evaluated for suspected sexual abuse: an update for 2008. Curr Opin Obstet Gynecol. 2008 Oct; 20(5):435-41.

INTERPRETATION OF FINDINGS

Table 1 Approach to interpretation of medical findings in suspected child sexual abuse

Findings documented in newborns or commonly seen in nonabused children (the presence of these findings generally neither confirms nor discounts a child's clear disclosure of sexual abuse)

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 (prepubertal girls), on or above the 3 o'clock to 9 o'clock line, patient supine
7. Shallow/superficial notch or cleft in inferior rim of hymen (below 3 o'clock to 9 o'clock line)
8. External hymenal ridge
9. Congenital variants in appearance of hymen, including: crescentic, annular, redundant, septate cribiform, microperforate, imperforate
10. Diastasis ani (smooth area)
11. Perianal skin tag
12. Hyperpigmentation of the skin of labia minora or perianal tissues in children of color, such as Mexican–American and African–American children
13. Dilation of the urethral opening with application of labial traction
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)

Findings commonly caused by other medical conditions

15. Erythema (redness) of the vestibule, penis, scrotum or perianal tissues (may be due to irritants, infection or trauma[a])
16. Increased vascularity ('dilatation of existing blood vessels') of vestibule and hymen (may be due to local irritants, or normal pattern in the non estrogenized state)
17. Labial adhesion (may be due to irritation or rubbing)
18. Vaginal discharge (many infectious and noninfectious causes; cultures must be taken to confirm if it is caused by sexually transmitted organisms or other infections)
19. Friability of the posterior fourchette or commisure (may be due to irritation, infection, or may be caused by examiner's traction on the labia majora)
20. Excoriations/bleeding/vascular lesions (these findings can be due to conditions such as lichen sclerosus, eczema or seborrhea, vaginal/perianal Group A *Streptococcus*, urethral prolapse, hemangiomas)
21. Failure of midline fusion (also called perineal groove)
22. Anal fissures (usually due to constipation, perianal irritation)
23. Venous congestion, or venous pooling in the perianal area (usually due to positioning of child, also seen with constipation)
24. Flattened anal folds (may be due to relaxation of the external sphincter or to swelling of the perianal tissues due to infection or trauma[a])
25. Partial or complete anal dilatation to less than 2 cm (anterior–posterior dimension), with or without stool visible.

MORE ON DOCUMENTATION

http://childabusemd.com/documentation/documenting-diagnosis.shtml

SUMMARY

- Here is what we talked about:
  - Explain why all children suspected of being sexually abused need a skilled medical examination
  - Describe appropriate medical management of a child sexual abuse case
  - Explain the best way to document a child sexual abuse case

Every child deserves a skilled medical exam when abuse is suspected.