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

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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?

- Presence of medical symptoms
- Based on her age
- Time since the incident
- Availability of medical care
- Parent request
- None of these

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...
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?

- Primary care physician, NP, or PA
- Child Abuse Pediatrician
- Emergency Department doctor
- Sexual Assault Forensic Examiner
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>
<thead>
<tr>
<th>Normal, Common Behaviors</th>
<th>Less Common Normal Behaviors</th>
<th>Uncommon Behaviors in Normal Children</th>
<th>Rarely Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needing/masturbing genitals in public/privacy</td>
<td>Pinching or touching others</td>
<td>Having persistent sex</td>
<td>Pinching or touching animals</td>
</tr>
<tr>
<td>Watching/performing porn on new social contact</td>
<td>Trying to insert in mouth</td>
<td>Having persistent sex</td>
<td>Pinching or touching animals</td>
</tr>
<tr>
<td>Asking children to penis</td>
<td>Picking up or inserting objects into genitalia</td>
<td>Handing possible to engage in genital activity</td>
<td>Pinching or touching animals</td>
</tr>
<tr>
<td>Caught sitting together</td>
<td>Picking up or inserting objects into genitalia</td>
<td>Handing possible to engage in genital activity</td>
<td>Pinching or touching animals</td>
</tr>
<tr>
<td>Taking discussion to others</td>
<td>Picking up or inserting objects into genitalia</td>
<td>Handing possible to engage in genital activity</td>
<td>Pinching or touching animals</td>
</tr>
<tr>
<td>Behaviors are transient, few, and disappear</td>
<td>Picking up or inserting objects into genitalia</td>
<td>Handing possible to engage in genital activity</td>
<td>Pinching or touching animals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Handing possible to engage in genital activity</td>
<td>Pinching or touching animals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Handing possible to engage in genital activity</td>
<td>Pinching or touching animals</td>
</tr>
</tbody>
</table>

* Assessment of situational factors: Climate, safety, children, new social contact contributing to behavior is recommended.
* Assessment of situational factors: Family characteristics: above, below, neglect, neglect is recommended.
* Assessment of all family and environmental factors: importance of precursors to medical condition.

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
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

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


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 TRAUMA
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

<table>
<thead>
<tr>
<th>Medical Care</th>
<th>Time</th>
<th>Weeks</th>
<th>Months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Acute &amp; Follow-up Examinations</td>
<td>Follow-up Exams</td>
<td>1 to 3 months</td>
<td>Exams for physical and emotional well-being may be done at any time</td>
</tr>
<tr>
<td>Infections Specimen Collection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Post Exposure Prophylaxis &amp; Testing</td>
<td>20 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy Testing &amp; Prevention</td>
<td>Follow-up Screen SaCG</td>
<td>1 to 2 months</td>
<td></td>
</tr>
<tr>
<td>STI Testing</td>
<td>Follow-up Screen 1 to 2 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STI Treatment</td>
<td>Treatment may be offered in the acute post assault setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary Tract Sexual Assault Testing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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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

<table>
<thead>
<tr>
<th>ST/SA Confirmed</th>
<th>Evidence for sexual abuse</th>
<th>Suggested action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhea*</td>
<td>Diagnostically</td>
<td>Report (6)</td>
</tr>
<tr>
<td>Syphilis*</td>
<td>Diagnostically</td>
<td>Report (6)</td>
</tr>
<tr>
<td>Human Immunodeficiency Virus*</td>
<td>Diagnostic</td>
<td>Report (6)</td>
</tr>
<tr>
<td>Chlamydia trachomatis*</td>
<td>Diagnostic</td>
<td>Report (6)</td>
</tr>
<tr>
<td>Trichomonas vaginalis</td>
<td>Highly suspicious</td>
<td>Report (6)</td>
</tr>
<tr>
<td>Condyloma acuminita (anogenital warts)*</td>
<td>Suspicious</td>
<td>Report (6)</td>
</tr>
<tr>
<td>Genital herpes*</td>
<td>Suspicious</td>
<td>Report (6)**</td>
</tr>
<tr>
<td>Bacterial vaginosis</td>
<td>Inconclusively</td>
<td>Medical follow-up</td>
</tr>
</tbody>
</table>


* If not likely to be perinatally acquired and 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.

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COCAN GUIDELINES: AAP

Adapted for 2006 CDC STD Treatment Guidelines
**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


- 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

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

<table>
<thead>
<tr>
<th>Finding</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intact hymen</td>
<td>Indicates absence of trauma or infection</td>
</tr>
<tr>
<td>Tears of hymen</td>
<td>May indicate trauma or infection</td>
</tr>
<tr>
<td>Lesions</td>
<td>May indicate trauma or infection</td>
</tr>
<tr>
<td>Erosions</td>
<td>May indicate trauma or infection</td>
</tr>
<tr>
<td>Abscesses</td>
<td>May indicate trauma or infection</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>May indicate trauma or infection</td>
</tr>
<tr>
<td>Erythema</td>
<td>May indicate trauma or infection</td>
</tr>
<tr>
<td>Swelling</td>
<td>May indicate trauma or infection</td>
</tr>
<tr>
<td>Ulceration</td>
<td>May indicate trauma or infection</td>
</tr>
<tr>
<td>Other findings</td>
<td>May indicate trauma or infection</td>
</tr>
</tbody>
</table>

(article continues)
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.