Sexual Abuse

Dr Burke Baird
Unlike physical abuse, where you are typically faced with a suspicious injury and you go looking for an explanation, with sexual abuse, you usually start with a verbal disclosure and then go looking for corroborative physical evidence.
But
95% of children who disclose sexual abuse have a totally normal physical examination.
Why?
Very few sexual abuse episodes result in actual tissue injury, even when the child reports pain and describes “penetration”

Even significant genital injuries can heal in a very short amount of time with no residual visible abnormalities.

There is often a delay between when abuse occurs and when it is disclosed.
Disclosures

- Often spontaneous
- Unless you have been trained in forensic interviewing, you should not be taking specifics of the disclosure history. You could contaminate the only evidence available of what really happened.
- If you are unclear of what a disclosure means and you need more detail to know if abuse is likely, use very open ended questions and write down verbatim what you said and what the child said.
- You still take the medical history and enumerate current or past symptoms associated with the alleged event.
What does “inside” mean?

- Not much.
- Between the legs/buttocks, between the labia majora, minora or up against the hymen.
- Prepubertal hymen is very pain sensitive. Child can experience pain just from contact.
Anderst et al. 2009

Of 74 girls < 10 years old with disclosure of repetitive penetrative abuse, none had any physical evidence of acute or healing injury.

Kellogg 2004

36 pregnant adolescent females
2 had visible evidence of previous hymenal injury
So, why do we do the examination?

- 1 in 20 examinations will be abnormal.

- Some children and most parents feel very reassured to know that everything is normal “down there”.

- It is an external, visual exam. It is not painful. It does not “traumatize” the child.

- We never force the exam. If the child is resistant, we stop.
Situations where we are more likely to see/find something.

- Alleged assault within 24-72 hours with symptoms of ongoing pain or report of bleeding. “Kit” may be worthwhile.

- Historical reports of abuse associated with symptoms of significant pain and/or bleeding.

- History of genital discharge suggestive of a possible sexually transmitted infection.
Doing the examination.

- Do the general physical exam first to establish rapport and screen for other issues.
- Start in the supine/frog leg position.
- Note SMR rating, appearance of the perineum and labia majora.
- Traction and separation of the majora will expose the minora, hymen and perihymenal tissues.
The Examination

• Note the shape of the hymen, any anatomic variants.
• Note any evidence of a medical condition and any evidence of acute or suspected healing injury.
• If there is a suspected abnormality of the posterior hymenal rim, try examining the child in the knee-chest position.

• You almost never need to touch the pre-pubertal hymen. There are extra techniques to visualize the hymenal edge if needed.
Whenever possible, get digital images of the examination. It won’t be used for court but is necessary for 2nd opinions and peer review.
The Report

• Typical consultation note with a few additions.

• Best to indicate your sources of information eg. FACS/CAS worker, police, parent etc.

• Indicate if you asked the child about the disclosure and if you did, indicate exactly what you asked and exactly what the child said.

• If the child makes spontaneous statements regarding the abuse, include these verbatim and the context of the disclosure.
The Report

• Describe the general physical exam and then the specifics of the genital and anal exams.

• Most important of all is the “impression statement”

• Gives the non-medical reader an understanding of what the physical findings mean in relation to the history/disclosure.
Impression Statement

• In most cases the examination is normal. So, the reader needs to understand why a normal exam does not rule out the possibility of the disclosure being true.

• If the exam is abnormal, to what degree, if at all, does it relate to SA (ie lichen sclerosis, HPV)

• Interpretation of acute or healing injury or STI
So, how do you know what to say?
Ask Dr Adams
The Adams Tool

- Developed and revised over the past 10-12 years as an evidence based guide to the interpretation of anogenital findings in sexual abuse examinations.

- Updated every 2-3 years or sooner if new important data arises.

- Very helpful in formulating impression statements

- Not a “classification system”, just a tool to aid in interpretation.
Data used to develop the tool.

- Findings that have been documented in newborn infants
- Children screened and selected for non-abuse.
- Case controlled studies of girls with a history of penetration compared to age-matched non-abused children.
- Girls who have experienced acute genital and anal injuries with follow-up examinations demonstrating healing.
- Children referred for examination for suspected sexual abuse.
- Findings from two studies comparing the appearance of the hymen in adolescent girls with and without a history of consensual intercourse.
- Studies on transmissibility of various infectious diseases.
Normal Variants
Normal hymen in a pregnant adolescent
Findings caused by other medical conditions and conditions commonly mistaken for abuse.
5 YEAR OLD WITH DISCHARGE
Indeterminate Findings
1. Deep notches or clefts in the posterior/inferior rim of hymen that extend through more than 50% of the width of the hymen

2. Deep notches or complete clefts in the hymen at the 3 o’clock or 9 o’clock location in adolescent girls

3. Marked, immediate anal dilation to an AP diameter of 2 cm or more, in the absence of other predisposing factors such as chronic constipation, sedation, anesthesia, and neuromuscular conditions

4. Genital or anal condyloma accuminata in child, in the absence of other indicators of abuse. Lesions appearing for the first time in a child older than 5–8 years may be more suspicious for sexual transmission.*

5. Herpes Type 1 or 2 in the genital or anal area in a child with no other indicators of sexual abuse. Isolated genital lesions caused by HSV-2 in a child older than 4–5 years may be more suspicious for sexual transmission.*
Findings Diagnostic of Trauma and/or Sexual Contact
1. Acute trauma to external genital/anal tissues
2. Residual (healing) injuries
3. Injuries indicative of blunt force penetrating trauma
4. PRESENCE OF INFECTION CONFIRMS MUCOSAL CONTACT WITH INFECTED AND INFECTIVE BODILY SECRETIONS;CONTACT MOST LIKELY TO HAVE BEEN SEXUAL IN NATURE
• Positive confirmed culture or NAAT for gonorrhea, from genital area, anus, or throat, in a child outside the neonatal period

• Confirmed diagnosis of syphilis, if perinatal transmission is ruled out

• Trichomonas vaginalis infection in a child older than 1 year of age, with organisms identified by culture or, in vaginal secretions, by wet mount examination
• Positive culture from genital or anal tissues or urine NAAT for chlamydia, if child is older than 3 years at time of diagnosis and if specimen was tested using cell culture or comparable method approved by the Centers for Disease Control

• Positive serology for HIV if perinatal transmission, transmission from blood products, and needle contamination have been ruled out
Diagnostic of Sexual Contact
• Pregnancy

• Sperm identified in specimens taken directly from a child’s body