CHILD SEXUAL ABUSE—II

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In child sexual abuse genital and anal examination should be in the context of a general clinical examination and include a search for other forms of abuse and an appraisal of growth, development, and health. The behaviour of the child in the presence of his or her parent should be noted.

Why should the genitalia be examined?

The genitalia should be examined in child sexual abuse for five main reasons.

- To detect traumatic or infective conditions that may require treatment
- To evaluate the nature of any abuse. Normal genital and anal appearances do not exclude the diagnosis, but in young children they make penetrative abuse unlikely
- To provide forensic evidence that may be helpful to the future protection of children
- To reassure the child, who sometimes feels that serious damage has been done
- To start the process of recovery.

How to examine the genitalia and anus

Cooperation during an examination is best achieved by telling children exactly what is happening and allowing them to feel in control by asking them to help. Let them take the swabs if they wish. The child may lie on her back for vulval inspection or on her side as for anal examination. With children up to 7 years old it is sometimes better for them to lie along the length of their mother's knee, facing forwards, with the mother gently flexing and abducting the hips. Adequate inspection requires a relaxed child.

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Right: Examine small children on their mother's knee

Far right: Glaister's rods: graduated glass globes of different sizes

Should fingers or a speculum be inserted?

Glaister's rods, if used gently in a cooperative child, may assist inspection of the edge of the hymen vaginalis but they are not absolutely necessary.

Some doctors insert a finger to assess the tone of the anal sphincter but unless there are clear indications of abuse it should be avoided. Views differ as to its importance.

In a small number of cases in which vaginal examination or repair is necessary the child should be given a general anaesthetic. General anaesthesia should also be considered if there is vaginal bleeding after suspected abuse.

Can sexual abuse be proved by clinical examination?

Semen or blood of a group different from that of the child would if present within the vagina or rectum, or on the perineum in a prepubertal child, be conclusive evidence of interference, but such cases are uncommon in forensic practice and wholly exceptional in paediatric practice. Lubricants or hairs are of similar importance. Genital infection with *Neisseria gonorrhoeae* is indicative of contact with an infected person in 98% of cases, but all other findings can be produced by circumstances or conditions other than sexual abuse. It follows that, with the exceptions mentioned, the concept of a single, conclusive, diagnostic sign is invalid.

How patent is a child's vagina?

The likelihood or otherwise of penetration may be inferred from the size of the hymenal orifice.

Right: Swabs for detection of sexually transmitted disease may be important; when possible let the child keep control and take swabs

Far right: Tear of hymen, left lateral, would have been missed without use of Glaister's rod

Individual hymens vary substantially from the imperforate to the congenitally absent, and the hymen may occasionally be cribriform. In most prepubescent children it is a membrane with a circular or crescentic opening and a smooth, regular margin that may be either thin or rounded.

The diameter is difficult to measure accurately but in most young children the unstretched hymenal orifice is no more than 0.5-0.6 cm. The diameter increases as puberty is approached. As the diameter of an adult index finger is about 1.5 cm and that of an erect penis two or three times greater an intact unstretched hymen precludes the possibility of penetration.

It is important to spend some time carefully observing the hymen before coming to any conclusion about it. A hymen appearing small and undamaged will sometimes open up as the child relaxes and tears and bumps may be seen.

What causes irregularity or tearing of the hymen?

The hymen may be damaged in four main ways.

- By sexual abuse
- By genital disease. A careful history is important
- By self injury. This is unusual because it is painful, but damage to the hymen may occur by the insertion of foreign bodies
- By accidental injury. This is also unusual because after infancy the introitus is protected by the labia.

Signs of intercrural intercourse

There are usually no signs of intercrural intercourse. It may cause patchy redness of the labia and perineum, but this is common in other conditions—for example, enuresis and poor hygiene. The rounded labial contour may be flattened, but it is not a reliable sign as flattening can be due to tight clothing. There may be a split of the posterior fourchette and a subsequent scar. Finally, the pressure of a penis against the hymen may stretch it and the child may think that there has been penetration.

Signs of buggery

The signs of buggery are likely to be most prominent in young children. There may be no abnormal signs but look for evidence of external trauma, skin changes, and anal dilatation.

External trauma in anal abuse

Perineal bruising or bleeding without a reasonable explanation raises substantial suspicions of abuse. They need to be distinguished from haemangiomas.

Fissures due to overstretching of the sphincter may be multiple and radiate. Their extent is probably in proportion to the disparity in size between the assailant and the child and the degree of force used, and they may leave scars and sometimes anal skin tags. Be careful to distinguish fissures from prominent folds in the anal canal.

Petechial bruising on palate. Always look in mouth for signs of oral sex

Below: Be careful not to mistake vestibule for hymen. On left vestibule is seen while on right closer picture of same child shows red crescent of hymen

Perianal skin changes

Swelling of the skin around the anal verge may be seen occasionally after recent abuse and thickening after repeated abuse. The skin of the anal verge may become rounded and smooth. Distinguish from lichen sclerosus et atrophicus, perianal moniliasis, and scratching by children infected with threadworms. Skin changes by themselves are not sufficient to lead to investigation of abuse.

Veins in the skin may become dilated giving a bruised appearance. Back pressure from the inferior rectal veins is implied and may be seen in abuse, but great caution is needed in interpretation, especially if there is any possibility of a bowel disorder.

Warts around the anus (or vaginal introitus) may be transmitted by genital contact. They are strongly suggestive of sexual abuse, especially if wart virus of a genitally transmitted type is

VARIATIONS IN HYMEN

Right: Two holes in hymen

Far right top: Septate hymen. Bands are usually vertical. Hymenal tags (not shown) may be incomplete bands and be mistaken for tears

Far right below: Bump on hymen. Hymen has probably been torn posteriorly leaving bumps and slight thickening

CLASSIC INJURY OF ATTEMPTED PENILE PENETRATION

Right: Haematoma of hymen and split of posterior fourchette

Far right top: Recently torn hymen in teenage girl. Hymen usually tears in posterior half

Far right below: Flattening of labia inferiorly. This may be caused by abuse from penis being pushed repeatedly against labia but may also be normal or caused by wearing nappies

Inflamed, thickened hymen, in this case caused by rubbing

Redness caused by rubbing

identified. Genital warts are usually smaller than common warts and appear as multiple papules along the inner surface of the labia or circumferentially around the anus. They occur particularly where skin is moist. Parents or children who have common warts on their hands may infect skin in the region of the genitalia or anus during toileting.

Anal dilatation

Given that the bowel is normal and that the child does not suffer from any neurological disorder, abnormal patency is indicative of something hard and large having passed through

the anus, but it is impossible to be sure whether the object has passed upwards or come downwards. A history of bowel problems or of medical investigation or treatment is therefore important. "Reflex" anal dilatation is not a true reflex. It amounts to relaxation of the anal sphincter about 10 seconds after the anus has been inspected so that an initially closed anus opens during the course of examination (alternatively an anus open at first closes during the examination and then opens again).

Anal closure and continence is dependent upon the internal anal sphincter. If it is incompetent because of stretching or injury there is likely to be soiling. The internal anal sphincter may be relaxed physiologically by faeces in the lower rectum. In examining children in whom abuse is suspected it is important to ensure that they are relaxed, that the rectum is empty, and that there is no other source of pressure on it. When the internal sphincter is incompetent the external sphincter may be able to maintain closure for a short time but cannot sustain it, hence the changes seen during examination. "Reflex" anal dilatation may be a pointer to sexual abuse but is not reliable as a sole diagnostic sign and its significance is currently unproved.

Should tests be done for sexually transmitted disease?

Sexually transmitted disease should always be tested for in children molested by strangers. In intrafamilial cases obtain swabs unless it is clearly going to cause distress. Sometimes it is helpful to get suspected abusing parents to attend a genitourinary medicine clinic.

Taking a low vaginal swab at the initial examination is usually appropriate, but it may need to be repeated within 10 days of contact. Prepubertal children with gonorrhoea have acute vaginitis and cervical or high vaginal swabs are not needed. Repetitive swabbing is usually unnecessary but serological tests for syphilis and chlamydia should be done six weeks or more after the last contact. Tests for antibodies to HIV may be required later in specific cases, as may pregnancy tests in postpubertal girls.

ANAL DILATATION

Right: Place hands gently on buttocks and wait

Far right: Both sphincters open. Do not pull with fingers as false positive results will occur. Ensure rectum is empty. (Note that faeces can be seen in this girl's rectum)

Buggery: Top pictures show swelling, bruising, and fissures of anal margin caused by recent buggery

Right: Anal dilatation, bruising and fissure

Far right: Appearance of healed anus 10 days later

Medical management

The medical management of child sexual abuse is part of an interdisciplinary process. Communication with other agencies is essential.

Possible sexual abuse

- (1) If child sexual abuse is only a possibility — for example, the child has made a vague statement, there are behavioural changes, vulval or anal soreness, or family risk factors — take a careful history from the carer and write down anything said by the child but do not engage in an intrusive interview.
- (2) If the history points to a probability of abuse refer the child to an experienced person.
- (3) If the history is not clearly indicative of abuse examine the whole child, including the genitalia, and take swabs if appropriate.
- (4) Discuss the case with colleagues in the practice, including health visitors and possibly school nurses. Hospital doctors should discuss

the case with the family's general practitioner. Some regions have experienced staff who are willing to advise. Ascertain whether the family are known by or have caused concern to the social services.

- (5) Tell the carer of your findings and opinion.
- (6) Arrange follow up visits and ensure that appointments are kept.

Probable sexual abuse

- (1) If child sexual abuse is probable because of a clear statement from the child or unexplained recent vaginal or anal injury inform the police and social services department promptly, with the knowledge and, if possible, the agreement of the carer.
- (2) Do not examine the child — arrange for a full, single paediatric and forensic examination at which suitable samples and photographs can be obtained.
- (3) Check that the medical welfare of the child

Genital and anal findings which may indicate abuse

has been safeguarded — that is, infections treated and, if appropriate, pregnancy tests and postcoital contraception provided.

(4) Facilitate interviews of the child by a psychiatrist, psychologist, police officer, or social worker agreed by all the parties concerned. Avoid further abuse of the child by preventing different people going over the same material repetitively.

(5) Ascertain whether there are other children at risk and arrange to examine them.

(6) Participate in a multidisciplinary case conference.

(7) Ensure long term follow up with child-psychiatrists as appropriate.

Allegations by an adult against another

When an adult accuses another adult of child sexual abuse refer the case to an experienced person because such cases often lead to litigation.

Violent sexual assault outside the family

Refer all cases in which children are violently assaulted outside the family to the police.

Do not touch or examine the child, except in an emergency.

Ensure the medical welfare of the child as in other cases but after forensic examinations are complete.

Almost all victims require skilled psychiatric help.

Confidentiality

The overriding duty is to the child. It is usually possible to obtain the consent of one parent to examination and disclosure — in any event you are obliged to make sure that the parent(s) understand that information will be shared.

Further reading

Department of Health and Social Security. *Diagnosis of child sexual abuse: guidance for doctors*. London: HMSO, 1988. Ciba Foundation. Porter R, ed. *Child sexual abuse within the family*. London: Tavistock, 1987.