# Recognition and Response to Child Sexual Abuse

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# Child Sexual Abuse/Assault

- High prevalence (10-20%)
- Perpetrators typically known to and loved by victim
- Frequently not reported to authorities
- Little "evidence" to substantiate case

# Medical Evaluation

- All children who are suspected victims of child sexual abuse should be offered a medical evaluation.

# Physical Examination

- To diagnose and treat medical consequences of abuse
- To diagnose and treat medical conditions unrelated to abuse
- To reassure the patient and family that the patient is normal, if they are.

# First do no harm.

- All aspects of the medical evaluation should be based on the best interests of the child.
- Constantly consider the benefit to the patient versus harm to the patient.

# AAP and CDC Guidelines Child Sexual Abuse

- Thorough exam by appropriately trained health care provider
- Not result in any additional physical or emotional trauma
- Depending on the history of abuse the examiner may decide to test for STI
- ~5% of children acquire STI from their victimization

# A case-control study of anatomic changes resulting from sexual abuse

Abbey B. Berenson, MD, Mariam R. Chacko, MD, Constance M. Wiemann, PhD, Clifford O. Mishaw, MD, William N. Friedrich, PhD, and James J. Grady, DrPH

- N=192 penetration "highly likely"
- age 3-8 yrs
- 97.5% normal exams

- A gynecologist specializing in child sexual abuse examined nearly 200 young girls whose abuse likely involved penetration. The overwhelming majority of those girls (97%) had normal exams.

**Genital Anatomy in Pregnant Adolescents: "Normal" Does Not Mean "Nothing Happened"**

Nancy D. Kellogg, Shirley W. Menard and Annette Santos

*Pediatrics* 2004;113:e67-e69

- N=36 pregnant teens
- mean age 15.1 years [12.3-17.8]
- 82% normal exams

- "One group of researchers studied 36 pregnant girls between 12 and 18 years of age. Because they were pregnant, the researchers knew they had penile-vaginal penetration. Even though they were all pregnant most of them had normal exams. In fact, only 2 of them had genital findings of vaginal penetration."

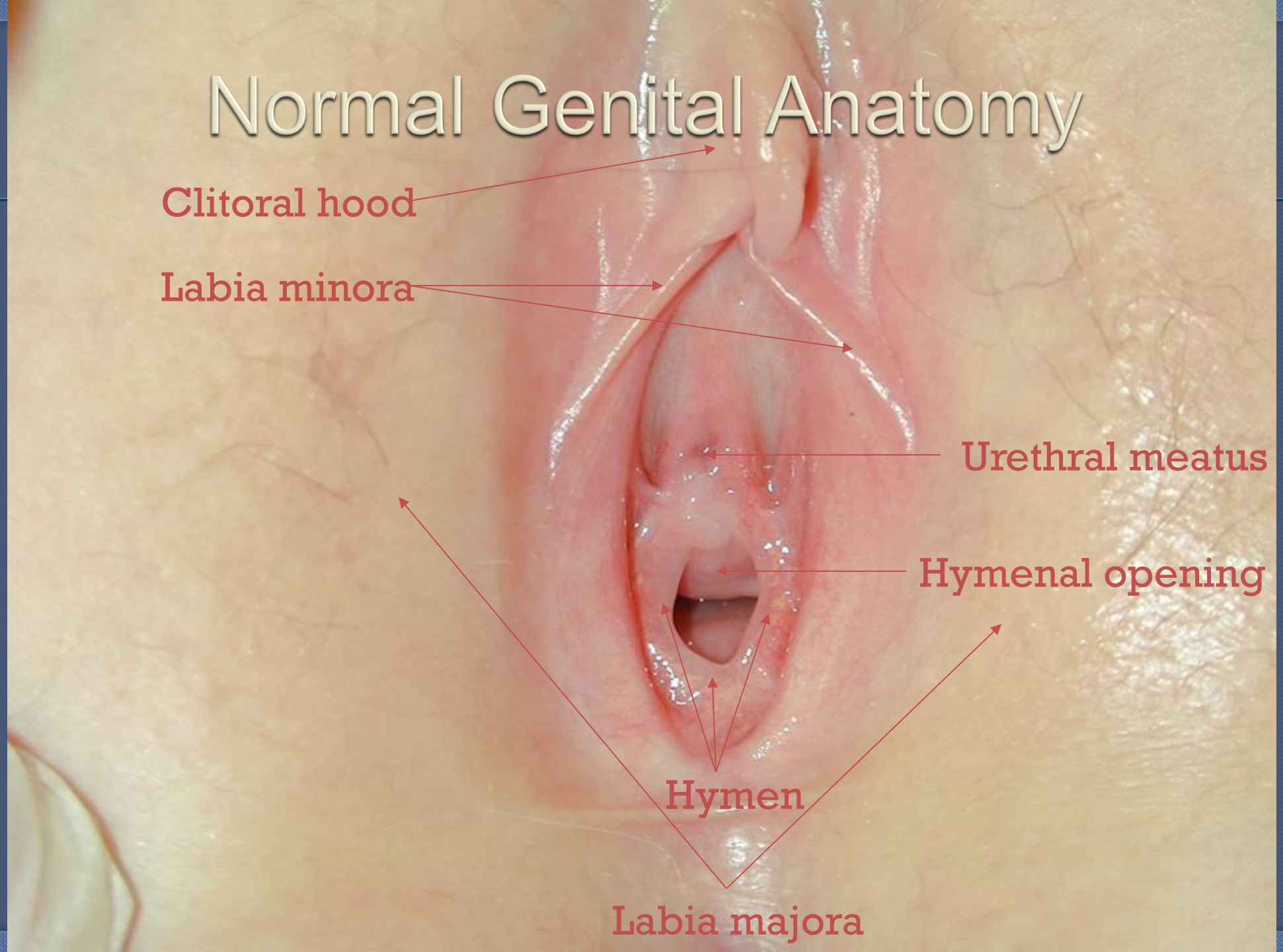
Pediatrics
September 2009, VOLUME 124 / ISSUE 3
Article

# Reports of Repetitive Penile-Genital Penetration Often Have No Definitive Evidence of Penetration

Jim Anderst, Nancy Kellogg, Inkyung Jung

- N= 506 females who reported penile-genital penetrative abuse
- Age 5-17 years
- 87% of victims who provided a history of >10 penetrative events had no definitive evidence of penetration

# Normal Genital Anatomy



# The Hymen

- All girls are born with a hymen
- All women die with a hymen
- The hymen changes over time
- The hymen can withstand trauma
- The hymen can heal from trauma

The best evidence is the verbal history from the child.

# Obtaining a History

- Only ask what is needed to treat the patient!
- Type of contact
- Timing of last contact
- Information about AP
- Symptoms
- Avoid leading questions
- Document child's disclosure verbatim!

# Timing

Timing of the examination should be based on specific screening criteria.

- Acute (Immediately)
  - Sexual assault (oral or genital contact) during last 72 hours (or other locally agreed time interval)
  - Child has evidence of injury or disease (ie pain, bleeding)
  - Intervention needed to assure safety (protection, suicidal ideation)
- Non-acute (Scheduled appointment)
  - All others

# Acute Evaluation

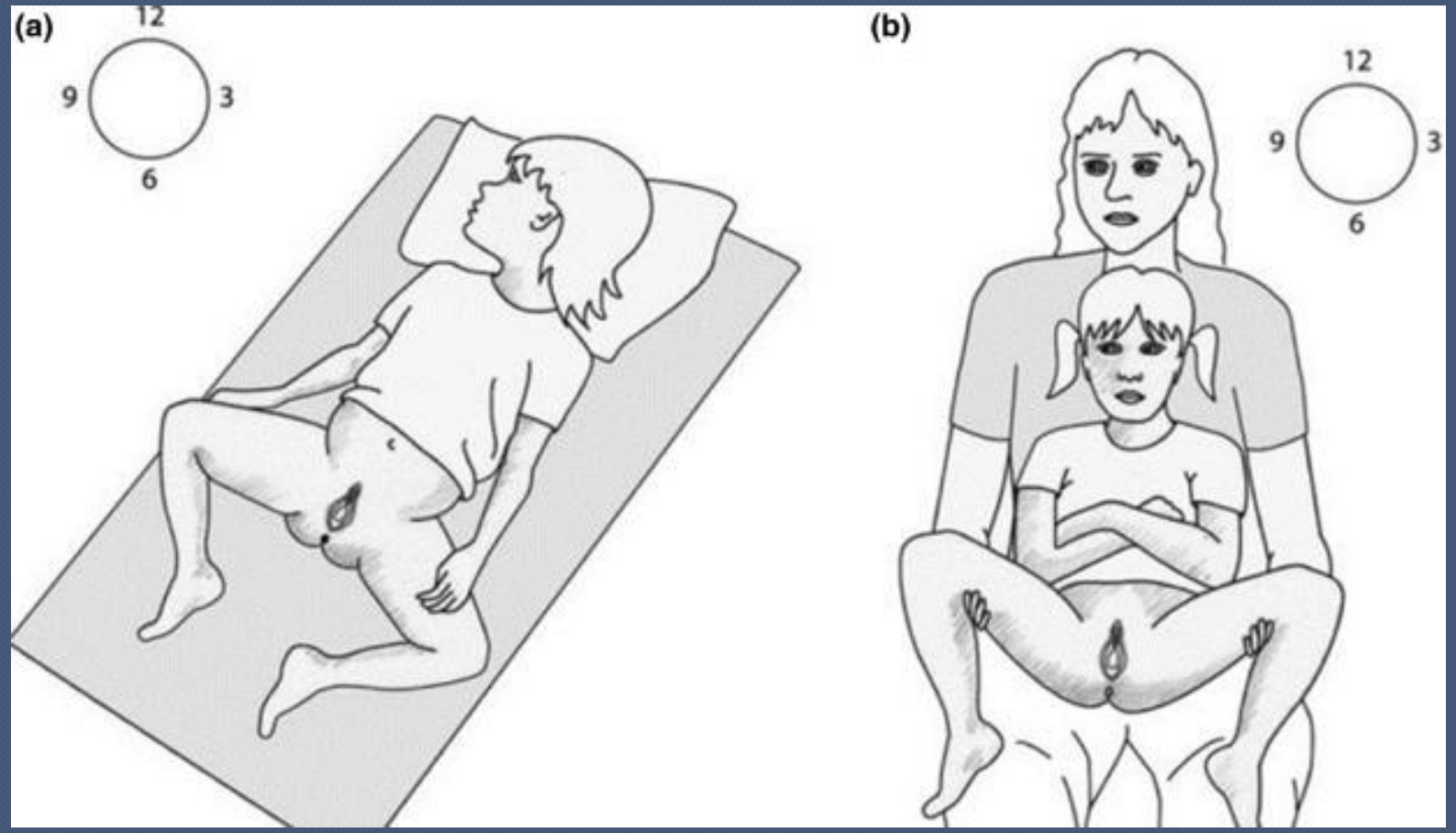
- Physical examination
- Photo-documentation
- Trace evidence collection
- STI sample collection
- Disease prevention
- Coordination with outside agencies
- Communicate with caregivers
- Coordinate follow-up care/mental health services

# Value of Forensic Evidence

- Protection of victim
  - To substantiate their verbal history
  - To provide appropriate medical/prophylactic care
  - To provide appropriate mental health services
- Protection of community
  - To facilitate criminal justice,
    - Criminal charges are 3 times more likely to be filed when forensic specimens were obtained.
    - Physical evidence was not predictive of a conviction.

# Examination Techniques

- Always have a chaperone
- Do a head to toe exam
- Use blankets/sheets to protect privacy
- Dedicate some time for the exam
- Child life
- If their exam is normal, tell them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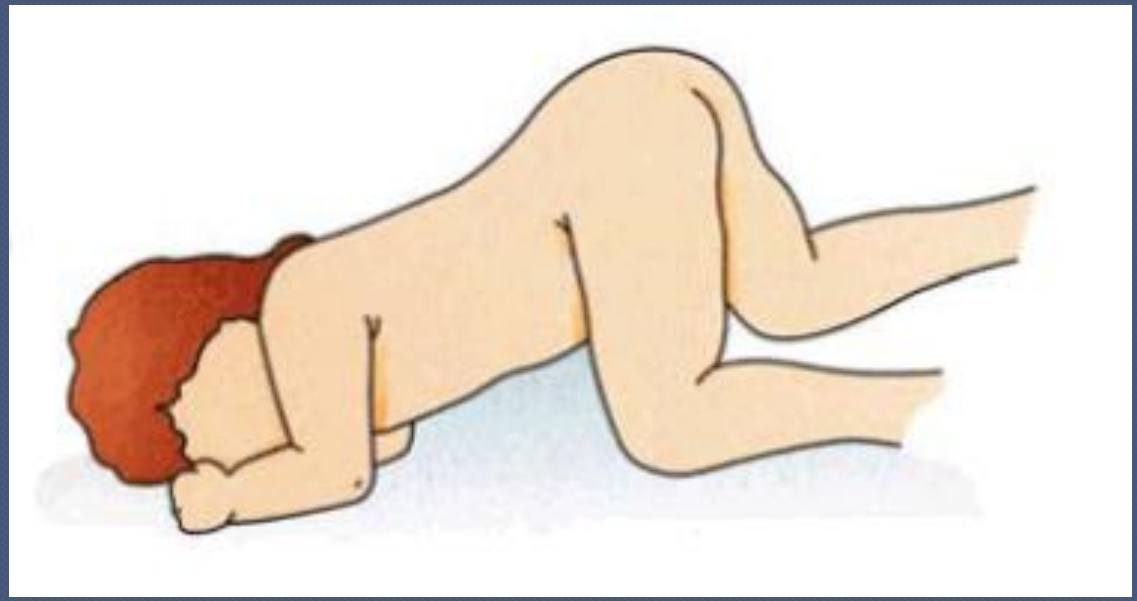

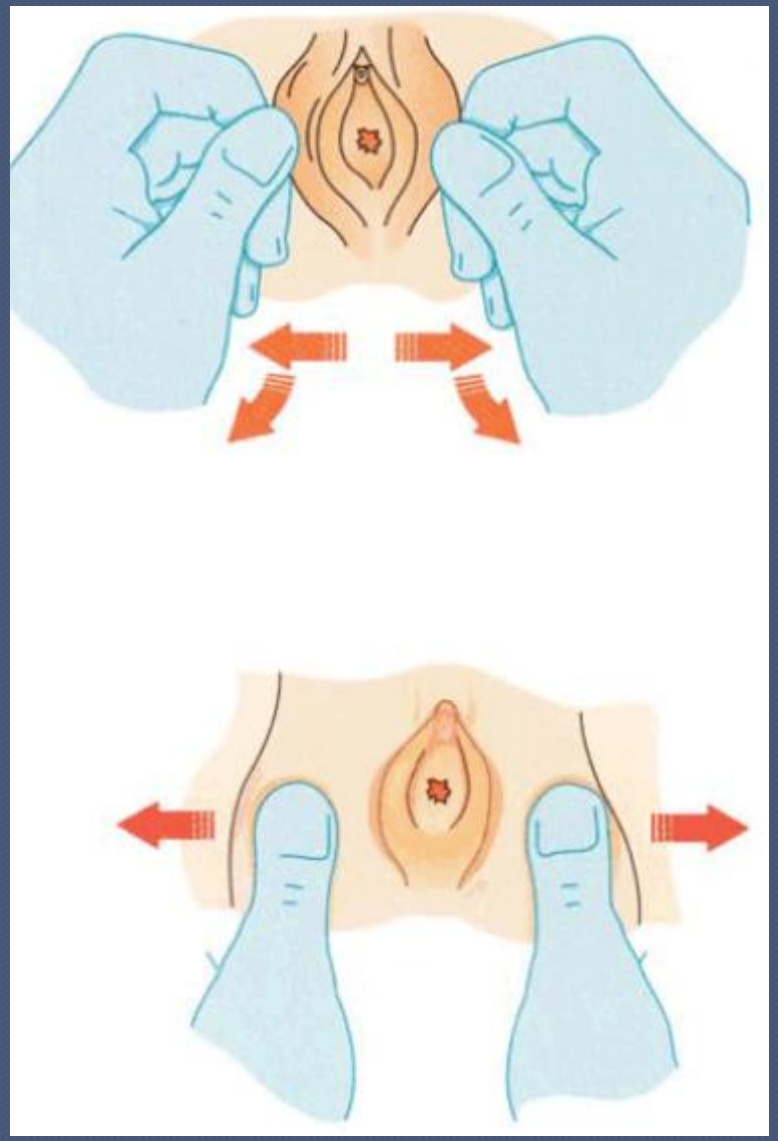

# STI Testing

# Post Pubertal vs Pre Pubertal

# Post Pubertal

- Recommend universal screening of post pubertal patients
- Testing before any prophylactic treatment
- Pregnancy testing before administering any medication

# Pre Pubertal

- Vaginal not cervical samples
  - Prepubertal hymen is very sensitive to touch
- Prophylaxis is NOT routinely given
  - If positive on initial screening need to confirm before treating

# Why don't we give prophylaxis?

- Not recommended for asymptomatic pre-pubertal children
  - Incidence of STIs is low
  - Risk of ascending infections is low
  - Follow up is more likely to be ensured (CPS, LE)
  - Side effects
  - Need to verify positive results

# Screening for STIs

- CDC Guidelines recommend NAA testing of N. gonorrhea, Chlamydia trachomatis, and Trichomonas vaginalis
- Consider urogenital, pharyngeal, and rectal testing
  - Incomplete disclosures
  - Contiguous spread from the genitals to the anus

Contents lists available at ScienceDirect

Child Abuse & Neglect

journal homepage: www.elsevier.com/locate/chiabuneg


Check for updates

# Interpretation of medical findings in suspected child sexual abuse: An update for 2023

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# Interpretation of Infections

- Infections not related to sexual contact
- Infections that can be spread by sexual transmission as well as non-sexual transmission
- Infections caused by sexual contact, if confirmed by appropriate testing, and perinatal transmission has been ruled out

# Infections Not Related to Sexual Contact

- Erythema, inflammation, fissuring of perianal, perineal, or vulvar tissues due to bacteria, fungus, virus or parasites that are transmitted by non-sexual means, such as Streptococcus Type A or Type B, Staphylococcus sp., Escherichia coli, Shigella or other gram-negative organisms
- Genital ulcers caused by viral infections such as Epstein Barr Virus

# Infections that can be spread by sexual transmission as well as non-sexual transmission

- Molluscum contagiosum in the genital or anal area
- Condyloma acuminatum (HPV) in the genital or anal area
- HSV types 1 or 2 in the oral, genital or anal area
- Urogenital Gardnerella vaginalis
- Urogenital Mycoplasma genitalium or ureaplasma urealyticum

# Infections caused by sexual contact, if confirmed by appropriate testing, and perinatal transmission has been ruled out

- Genital, rectal or pharyngeal Neisseria gonorrhea infection
- Syphilis
- Genital, rectal or pharyngeal Chlamydia trachomatis infection
- Trichomonas vaginalis infection isolated from vaginal secretions or urine
- HIV, if transmission by blood or contaminated needles has been ruled out

# Testing Summary

- NG, CT swabs
  - Consider oral, genital, anal
- Trich swab
- If vaginal discharge, pruritis, malodor test for BV and candida
- Serum HIV, Hep B, Hep C, and syphilis

# Prophylaxis

- Recommended for all post pubertal females
  - High prevalence of preexisting asymptomatic infection
  - Risk of PID
- Post exposure HepB vaccine adequately protects against hepatitis B virus
  - Give at initial exam if not received and complete series (1-2 mo then 4-6 mo)
  - If perpetrator is known to be HBsAG positive also give HBIG

# Prophylaxis

- Offer pregnancy prophylaxis if patient presents within 5 days of assault
- Offer HPV vaccine if unvaccinated and if patients is 9 years of age or older

# Treating STIs

- Due to antibiotic resistance, prophylactic treatment recommendations have changed
- Gonorrhea and chlamydia
  - Ceftriaxone 500mg IM
  - Doxycycline 7 days
  - Noncompliance can give azithro x 1
  - May require retesting
- Trichomonas
  - Metronidazole 2g PO x 1
- Bacterial Vaginosis
  - Metronidazole 500mg PO BID x 7 days

# Treating STIs

- Pre pubertal recommendations:
  - Chlamydia
    - <45 kg: Erythromycin base or ethylsuccinate 50 mg/kg body weight/day orally divided into 4 doses daily for 14 days
  - Gonorrhea
    - <45 kg: Ceftriaxone 25–50 mg/kg body weight IV or IM in a single dose, not to exceed 250 mg IM
  - Trichomonas
    - <45 kg: Metronidazole 15 mg/kg PO x 1 (max 2gm)
  - Bacterial vaginosis
    - <45kg Metronidazole 15 mg/kg PO x 1 (max 2 gm)

# Follow Up

- STIs acquired in assault might not have resulted in positive test results at initial acute exam
- If prophylaxis given- retest only if symptoms
- If no prophylaxis given- consider repeat exam in 2 weeks to relay results, retest and treat

# Follow Up

- Syphilis and HIV testing repeated at 6 weeks and 3 months post-assault
  - HIV testing recommended again at 6 months
- Hep B testing if child is unimmunized

# Thanks for your attention!