Child Sexual Abuse: Understanding the Role of Medical Assessment and Intervention

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I have no disclosures
Learning Objectives

• Understand role of medical examination and approach to acute versus non-acute sexual abuse assessment

• Understand the medical examination is often normal or may show mimics (conditions confused for abuse) – positive physical findings are uncommon

• Understand features of the “diagnosis” of sexual abuse

• Explain the indications and use of forensic evidence collection
Sexual abuse is a type of maltreatment that refers to the involvement of the child in sexual activity to provide sexual gratification or financial benefit to the perpetrator, including contacts for sexual purposes, molestation, statutory rape, prostitution, pornography, exposure, incest, or other sexually exploitative activities.
Triage Process

• Determine what Child Protection Team (CPT) services the child needs and when.
  o Contact CPT on call case coordinator for your region.

• CPT services available: Forensic interview of verbal children, specialized interview of caregivers or other family members, medical examination, multidisciplinary staffing, victim’s advocacy support, and court/deposition testimony.

• Once services are determined, decide timing of services with CPT and law enforcement (LE).
## Exam Timing: Acute

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Challenges</th>
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</thead>
<tbody>
<tr>
<td>Evidence Collection</td>
<td>Child may not be able or willing to communicate</td>
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<tr>
<td>Injury Assessment</td>
<td>May not be able to initiate or give warm hand off to counseling after hours</td>
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<tr>
<td>Provide Reassurance</td>
<td>Other investigative information may not be available – early in the investigation</td>
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<tr>
<td>Initiate Treatment/Referral</td>
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<td>(victim’s advocate)</td>
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## Exam Timing: Non-Acute

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Challenges</th>
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</thead>
<tbody>
<tr>
<td>Can be scheduled when child is able to communicate</td>
<td>Coordination with investigation</td>
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<tr>
<td>Can provide direct hand off to counseling</td>
<td>Child/Family may not come to appointment</td>
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<tr>
<td>More information may be available to inform forensic interview or medical examination</td>
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<tr>
<td>Provide reassurance and initiate treatment/referral</td>
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Acute Examination - Indications

• Child has trauma, pain, bleeding, or other significant symptom in genital or anal area
• Emergency prophylaxis is indicated
• There is a probability of acute trauma
• Forensic evidence should be collected during reliable time frame
• When recent drug or alcohol use is suspected
• Child with significant anogenital symptoms may require specific medical treatment and/or reassurance
• Emergency prophylaxis time frame limited
• Acute injury may have some forensic value but can heal rapidly

*Consensus is 72 hours for forensic acute time frame

*Forensic interview should be coordinated with the medical evaluation when at all possible.
  • Allows for more accurate evidence collection, may help to define further treatment or work-up
Examination Goals

- To reassure the child and/family related physical injury and address misperceptions
- To counsel related to safety and prevention
- Determine if there is risk of re-abuse or revenge from perpetrator (Determine if threats made to child, if able)
- Determine if the child has homicidal or suicidal ideation
- To identify injuries that need treatment
- To reduce the risk of pregnancy, if applicable
- Document potential forensic information
- To identify and treat STIs
- To ensure mental health treatment is initiated immediately
Delayed/Non-Acute Disclosure

- “All children who are suspected victims of child sexual abuse should be offered an examination performed by a medical provider with specialized training in sexual abuse evaluation.” (Adams et al, 2016)

- Forensic interview should be coordinated with the medical evaluation.

- This assessment can be scheduled when the child is awake, able to communicate and when team can coordinate services.

History

- History is most important as diagnostic physical examination findings are often absent.

- IT IS NORMAL TO BE NORMAL - >90% of physical examinations have no findings of trauma or sexually transmitted infection (STI) (Majority of cases present after injuries heal, non-acute.)
  - Use open-ended questions. (“Can you tell me why you are here?” versus “Did XX touch you here?”)
  - Avoid having the child repeat history multiple times.
  - Ask questions that help to determine safety, treatment needs. Ask details that may help determine what happened when child is hesitant to disclose actual assault. (Do you have pain anywhere, when did it start? Does it hurt to pee (urinate) or make stool? Does your throat hurt? When did that start? What happened right before?
  - Avoid leading and suggestive questions.
  - Interviews with verbal children and adolescents should be done without other family members present.
Magnification should be used to obtain adequate visualization of anatomy.

- Colposcope with camera attached
- 35-mm camera with a macro lens, or
- Digital camera/camcorder capable of high-resolution images with or without magnification
- Video recordings have the advantage of documenting sections of the examination in a dynamic state
- Light source and/or alternative light source 450 nm

Photo Documentation - Video is better than still photos; however, many sites are not set up to do or store videos. One study showed better identification of hymen transection, important because healed transection is the only non-acute hymen physical finding that is clear evidence of past injury.

Any abnormal or indeterminate finding should be viewed in more than one examination position; may also use other verification techniques – use of swab to highlight transection or intact hymen.

Children may refuse all or part of the examination, including photo-documentation.
Physical Examination

- Growth measurements and general examination
- Oral cavity for forced penetration (frenulum tear of bruising/petechiae of hard/soft palate)
- Look for other signs of assault/injury (strangulation, bruises on back/buttocks, ligature marks)
- Female genitalia
  - USING MAGNIFICATION: Visualize entire external genital surface - usually in the frog-leg position (knee-chest for better look at hymen). Document position in exam note, draw picture or take photos (if able – it is standard, but child may not cooperate or agree).
  - Assess for STI if significant vaginal discharge in a pre-pubertal girl or urethral discharge in pre-pubertal male.
  - **Pre-pubertal girls rarely need a speculum exam**
    - If there is bleeding of unknown etiology, then this is urgent, and child should be referred to Ped Surgeon or OB/GYN in ER for evaluation of internal trauma.
  - Speculum exam may be necessary in pubertal girls.
  - More likely to test for STI in pubertal girls and boys. Baseline prevalence of STIs is higher in this age group.
• Physical examination findings or laboratory abnormalities are uncommonly found in pre-pubertal children or in adolescents.

• A specific detailed history of a sexual act from the index child or a witness is the most common presentation of sexual abuse.

• THE ABSENCE OF PHYSICAL FINDINGS DOES NOT RULE OUT ABUSE WHEN A CLEAR, SPECIFIC HISTORY IS OBTAINED.
Child Modifications to Examination

• Allow child control over pace of process.
• Use distractors – iPads, stuffed toys - allow to help with exam.
• Limit uncomfortable procedures and move any to end of collection.
• Speculum examinations or cervical specimen collections are not commonly needed.
• Time frame considerations; if >72 hours – the best forensic interview is when the child is awake, fed, and rested.
• For crime scene: Remember the clothes, bed clothes, glasses/cups, bottles (Drug Facilitated Sexual Assault).
Evidence is collected in all cases where sexual contact is reported <72 hours prior; there may be individual considerations to extend time frame – to be discussed with local CPT for individual cases.

Evidence collected includes:
- Swabs: DNA via swab of appropriate areas, evidence of sperm (PSA, semenogelin)
- Clothing, underwear, sheets (if at scene – law enforcement)
- Cups, glasses, bottles at scene – law enforcement
- Urine for toxicology screen

Evidence collection process should be established with local law enforcement including provision of evidence kits, handoff procedure, and storage of evidence.
Adolescents are more likely to be tested or offered testing for STI due to high prevalence in this population.
  - This includes gonorrhea, chlamydia, trichomonas, HIV, syphilis, hepatitis

Prepubertal children without signs or symptoms are less likely to be tested. Exceptions if guardian requests or if details of prolonged abuse or penetration.

All children and adolescents with a history of penile penetration should have testing for syphilis, hepatitis and HIV.

All adolescents evaluated for recent sexual abuse or human trafficking, after testing, should be offered preventative treatment for: gonorrhea, chlamydia, trichomonas, HIV – if exposure is within the timeframe for prevention (<72 hours).

Adolescents should have prophylaxis if sexual activity disclosed within 60 days or if discharge.

Statewide CPT has documented testing and treatment guidelines based upon national recommendations. (CPT Handbook, page 74, 2019 version)

There is a program in many areas of the state for post exposure prophylaxis for HIV – NPEP prophylaxis. This program is time sensitive – as prophylaxis is NOT EFFECTIVE >72 hours after exposure.

Diagnosis

- Diagnosis is a probability statement.

- Interpretation of findings related to sexual abuse involves the following:
  - Physical findings (of trauma, mimics, normal variants)
  - Presence or absence of infection
  - Findings diagnostic of sexual contact
    - Semen
    - Pregnancy

- Diagnostic Findings:
  - Normal examination
  - Findings caused by other conditions
  - Findings with no expert consensus/indeterminate
  - Findings caused by trauma or sexual contact

• Medical evaluation has both health and forensic goals. Refer all children with alleged sexual abuse, coordinate investigation as part of Sexual Assault Response Team process.

• History is a critical part of the evaluation. It is normal to be normal.

• Examination usually involves magnification/colposcopy and photo-documentation. Some children do not cooperate. Best attempt at visualization will be made.

• DNA or sperm evidence is rarely found in children after sexual assault - when it is found, more often found on clothes. Almost never found on body after 24 hours.
References

- https://www.justice.gov/ovw/file/846856/download
- https://www.justice.gov/ovw/page/file/1090006/download
- Anderst, J., Kellogg, N., Jung, I. Reports of repetitive penile-genital penetration often have no definitive evidence of penetration.
Contact Information

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