

Facilitator Preparation: Facilitators should thoroughly review this module. They should also prepare or photocopy handouts to distribute during the course of the case presentation and the “Materials for Learners” packet.

Open the Discussion: Introduce the case title and the objectives of the session. Explain that this will be an interactive case discussion prompted by a series of multiple choice questions and not a lecture. Distribute Part I of the case and ask one or more of the participants to read it aloud.

Margaret’s Secret Sexual Abuse

Case Author:

Ranee Leder, MD
Ohio State University College of Medicine
Nationwide Children's Hospital

Expert Content Reviewer:

Jean Emans MD
Harvard Medical School
Boston Children’s Hospital

Objectives:

- Discuss the signs and symptoms of child sexual abuse.
- List important elements of the history and physical exam when sexual abuse is suspected.
- Discuss indications for filing a report of suspected child sexual abuse to a child protective services agency and the components of a CPS investigation.

Part I:

Introduction:

Margaret is a 5-year old girl who comes to your office for evaluation of genital discomfort and bedwetting.

Current History:

Her mother has noticed irritation and redness of Margaret’s vulvar area during the last week and that she has been wetting the bed for the past two weeks after having been fully toilet trained. She tells you that Margaret has had no vaginal discharge or bleeding, and has otherwise been healthy.

Mother denies that Margaret has any urinary frequency, urgency, or day time wetting. She reports some dysuria. When you ask if there have been any changes in child’s behavior, Margaret’s mother appears distressed and she asks to speak to you alone. Margaret is reluctant to leave the room without her mother but finally accompanies your assistant to the play area.

Mother tells you that, for the past week, Margaret has seemed unusually anxious. She has been reluctant to separate. The teacher reported that Margaret seems withdrawn, and somewhat hesitant about joining in activities that used to be her favorites. You find out that the family returned two weeks ago from a visit with Margaret’s aunt and uncle. Three days into the visit, Margaret refused to stay alone with her uncle stating to her mother that “*I don’t like Uncle Bob.*” Margaret’s mother found these statements concerning but when she asked further questions, Margaret refused to elaborate.

Past Medical History:

You check back in your notes and find that up to this point, Margaret’s behavior and

development have been entirely normal.

Following this reading, ask all participants “So what do you think about this case? What would you like to focus on during our discussion today?” List agenda items on a blackboard or flipchart. Then use the questions below to guide the discussion. Remember that the key to successfully leading a small group is facilitation of the discussion rather than lecture. Draw as many participants as possible into the discussion. Allow silences while group members think about questions.

Potential Discussion Questions:

What additional historical information would you like?

- Any recent changes in the family, which may have led to Margaret’s behavioral difficulties. Parental conflict, financial stresses, a death in the family, a new baby, a recent move, or starting a new school can all contribute to behavioral dysfunction in children.
- Given the history of vulvar irritation, you should get more information regarding the use of any new soaps, lotions, or bubble-baths, as well as whether child has been wearing any tight-fitting clothing such as leggings or leotards. New onset urinary incontinence at night may also contribute to vulvar irritation.
- Elicit further history regarding other areas of Margaret’s functioning. Ask questions about appetite, sleep pattern, relationships with peers, school function, and the presence of separation anxiety. While impairments in these areas are not specific for child sexual abuse, knowing about these difficulties can help you advocate for appropriate psychological support whatever the cause.
- Rectal or genital pain or bleeding, presence of a sexually transmitted infection, sexualized behaviors or precocious sexual knowledge are all associated with child sexual abuse. Exposure to explicit media (i.e., television, movies, Internet) may also contribute to sexualized behavior, but any child exhibiting such symptoms should be thoroughly evaluated so that sexual abuse can be reasonably excluded.

What is on your list of differential diagnoses for Margaret’s genitourinary and behavioral complaints?

- The differential diagnosis of vulvar erythema includes nonspecific vulvovaginitis (due to hygiene and/or irritants), specific vaginitis (e.g. Group A streptococcal infection, candida), a sexually transmitted disease (gonorrhea, chlamydia, trichomonas), vulvar dermatoses (eczema, psoriasis) or a vaginal foreign body.
- Enuresis could be the result of a neurologic disorder, urinary tract infection, or diabetes. A new onset urinary tract infection could explain the vulvar erythema and incontinence, but is likely to be associated with daytime symptoms and unlikely to be associated with behavioral symptoms. Enuresis may also be the result of normal maturation.
- Behavioral difficulties could be due to a psychological disorder, such as anxiety or depression.
- Margaret’s genitourinary and behavioral symptoms can certainly be seen in child sexual abuse, although they are not specific for this diagnosis.

What steps should you take next?

- Always perform a careful history and a physical exam. Avoid tainting the interview with leading questions and defer detailed sexual abuse and disclosure interviews to

experts unless you have been specially trained. The parent interview should be conducted separately from the child, and the child should be interviewed separately from the parent if possible. Clinicians must set aside adequate time to conduct these interviews and interruptions must be avoided.

- The anogenital exam is best performed in the context of a complete physical exam. The vulva and hymen may be well visualized in the supine frog leg position. If the edges of the hymen cannot be assessed or there is bleeding or discharge, the knee-chest position is useful to examine the contours of the hymen and to examine the vagina. Children who are reluctant to have these areas examined will often feel more comfortable sitting on their parent's lap or beside their parent (or other supportive person) on the exam table.

Distribute Part II of the case and have participant(s) read it aloud.

Part II

Next Steps:

Additional History:

Margaret's mother denies that Margaret has been using any new soaps, bubble baths, or lotions. Margaret has never had prior urinary tract infections. There have been no recent psychosocial stressors in the home. Up to this point, Margaret had been doing well at school. There have been no changes in Margaret's appetite, but she has recently had problems falling asleep.

Physical Exam:

You find Margaret in the playroom and invite her back into the exam room. As you re-enter the room, your nurse informs you that Margaret's urine is negative for leukocyte esterase, nitrites, and glucose. You have Margaret's mother sit next to her on the exam table. She tolerates the general physical examination well. The neurological examination is normal. Margaret becomes somewhat anxious during the genital exam. Margaret's anal area and hymen appear completely normal. She has slight vulvar erythema. No discharge is present. You end the exam just as Margaret begins to cry, "I don't like people to touch me there."

Pause and begin next set of discussion questions.

Potential discussion questions:

What do you think about the physical exam findings?

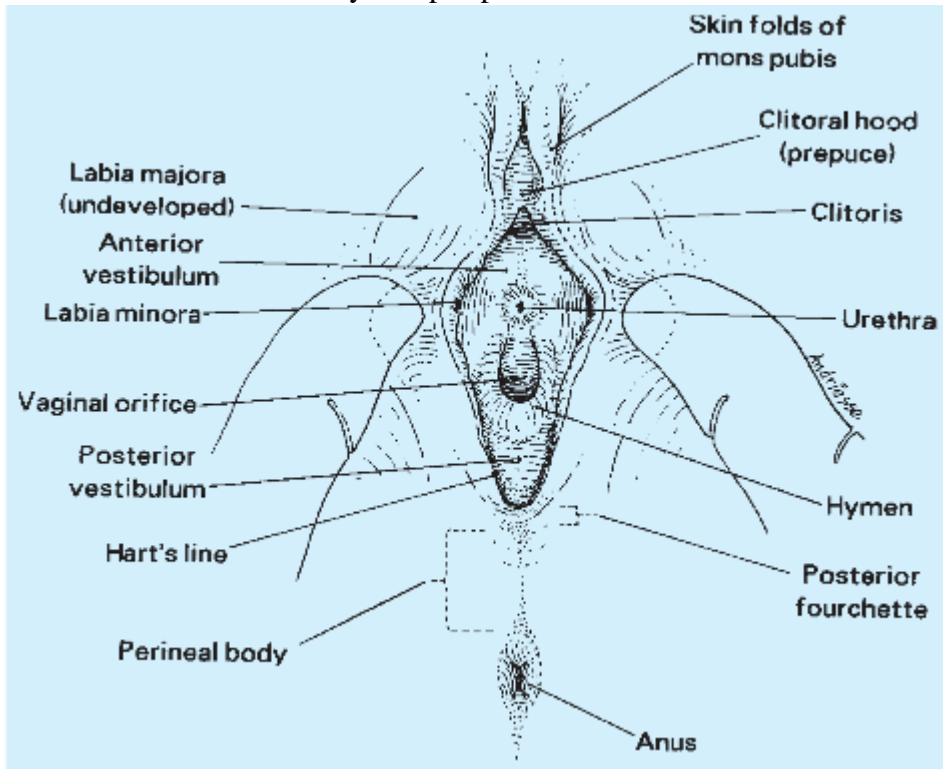
- Most survivors of sexual abuse have normal or nonspecific anal and genital exams. Therefore, a normal or nonspecific exam does not rule out the possibility of sexual abuse.
- Positive physical findings of sexual abuse occur in only 3 to 16% of victims.
- The healing process may quickly obscure any evidence of genital or perianal injury.
- Clinicians should be explicit in noting the physical findings of the genital examination. The hymen should be described in as much detail as possible, and the presence or absence of scars and bruises should be recorded.
- Most sexual abuse in young children involves fondling or vulvar contact with no resulting trauma and a normal hymenal examination. There are a number of good references with color plates depicting normal and abnormal hymenal and vulvar findings (see references #7, 9, 12).
- Classification systems for physical findings in child sexual abuse have been described (see references #1 and #13). Findings suggestive of hymenal penetration include a scar

or fresh laceration of the posterior fourchette and a hymenal transection or bruising. Definitive and specific findings are more common in children who reported genital-genital assault than in those who reported digital contact. Remember that both perpetrators and victims may report “vaginal penetration” when *vulvar* coitus has occurred.

Distribute Figure #1(without labels): External Genital anatomy in a pre-pubertal child. Allow a few minutes for students to work together to label the figure and point out the physical findings the examiner may see.

After reviewing answers, ask learners to refer to Figure 1 in the “Materials for Learners” packet

Figure 1: External Genital anatomy in a pre-pubertal child



(With permission from S.J. Emans and M.R. Laufer, *Emans, Laufer, Goldstein's Pediatric and Adolescent Gynecology*, 6th ed. Lippincott, Williams & Wilkins; Wolters Kluwer, 2012)

Next, have learners turn to and review Table 1 in their packet: Classification of Ano-genital Findings in Children with Suspected Sexual Abuse in their packets.

TABLE 1. Two classification systems for assessing physical and laboratory findings in suspected child sexual abuse

A. Muram Classification System

- Category 1 Normal-appearing genitalia
- Category 2 Nonspecific findings: abnormalities of the genitalia that could have been caused by sexual abuse are also seen in girls who are not victims of sexual abuse (e.g., inflammation, non-specific vaginitis, scratching) such as erythema, increased vascularity, purulent discharge, labial adhesions, and fissures.
- Category 3 Specific findings: strongly suggesting sexual abuse, such as recent or healed lacerations of the hymen and vaginal mucosa, indentations in the skin indicating teeth marks (bite marks), and STIs.
- Category 4 Definitive findings: any presence of sperm

B. Adams Classification System

I. Findings documented in newborns or commonly seen in non-abused children

A. Normal variants

- Periurethral/vestibular bands
- Intravaginal ridges/columns
- Hymenal bumps/mounds
- Hymenal tags/septal remnants
- Linea vestibularis
- Hymenal notch/cleft in anterior half of hymenal rim, on/above 3–9 o'clock line
- External hymenal ridge
- Congenital hymenal variants: crescentic, annular, redundant, septate, cribiform, microperforate, imperforate
- Diastasis ani
- Perianal skin tag
- Hyperpigmentation of labia minora/peri-anal tissues in children of color
- Urethral dilation with labial traction
- Thickened hymen

B. Findings caused by other medical conditions

- Erythema of vestibule, penis, scrotum, or peri-anal tissues
- Increased vascularity of vestibule and hymen
- Labial adhesions
- Vaginal discharge
- Friability of posterior fourchette or commissure
- Excoriations/bleeding/vascular lesions
- Failure of midline fusion
- Anal fissures
- Venous congestion/pooling
- Flattened anal folds
- Partial/complete anal dilation to less than 2 cm with/without stool visible

II. Indeterminate Findings: Findings which may require further studies/evaluation to determine significance. May support child's disclosure of abuse (if given) but should be interpreted with caution if child gives no disclosure. May require report to child protective services to further evaluate possible sexual abuse.

A. Physical findings

- Deep notches/clefts in posterior/inferior rim of hymen in prepubertal girls
- Deep notches/complete clefts in the hymen at 3 or 9 o'clock in adolescents
- Posterior rim of hymen which appears to be less than 1 mm wide in prone knee chest position or using water to float hymen edge when child is supine
- Apparent ano-genital warts
- Vesicular lesions/ulcers in ano-genital area
- Marked, immediate anal dilation to a diameter of 2 cm or more in absence of chronic constipation, sedation, anesthesia, neuromuscular conditions.

B. Lesions with confirmed etiology which have indeterminate specificity for sexual transmission (Report to child protective services recommended by AAP guidelines unless perinatal or horizontal transmission considered likely)

- Ano-genital condyloma acuminata in a child in absence of other abuse indicators
- Ano-genital herpes 1 or 2 in child with no other indicators of abuse

III. Findings diagnostic of trauma/sexual contact: Findings which support a disclosure of sexual abuse (if one is given) or in absence of clear, timely, plausible history of accidental injury

A. Acute trauma to external genital/anal tissue

- Acute lacerations/extensive bruising of labia, penis, scrotum, perianal tissues, or perineum
- Fresh laceration of posterior fourchette

B. Healing injuries (difficult to assess unless acute injury was previously documented at same location)

- Perianal scar
- Posterior fourchette/fossa scar

C. Injuries indicative of blunt force penetrating trauma (or of abdominal/pelvic compression injury if such history is given)

- Acute laceration (partial or complete) of hymen
- Ecchymosis on hymen
- Peri-anal laceration extending deep to external anal sphincter
- Healed hymenal transection
- Absence of hymenal tissue in posterior half of hymenal rim

D. Presence of infection confirms mucosal contact with infected bodily secretions, contact most likely to have been sexual in nature

Positive confirmed culture for gonorrhea from genitalia, anus, throat outside neonatal period
Confirmed diagnosis of syphilis, if perinatal transmission ruled out
Trichomonas vaginalis infection in child older than 1 year of age
Positive culture from genitalia or anus for Chlamydia in child older than 3 years of age
Positive serology for HIV, if perinatal/blood products/contaminated needle transmission ruled out

E. Diagnostic of sexual contact

Pregnancy
Sperm identified in specimens taken by directly from child's body

Muram Classification System adapted From Muram D. Classification of genital findings in prepubertal girls who are victims of sexual abuse. *Adolesc Pediatr Gynecol* 1988;1:149-151. Adams Classification System adapted from Adams J, Kaplan R, Starling S, et al. Guidelines for medical care of children who may have been sexually abused. *J Pediatr Adolesc Gynecol* 2007;20:163-72.

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Distribute the following pictures (Figures 2A and 2B). Ask participants to describe exam findings and potential concerns.

- A) Congenital anomaly: microperforate septate hymen and vagina. This is a normal variant and does not indicate abuse.



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- B) Exam findings in this pre-pubertal girl reveal a hymen with a normal smooth edge but a several tiny submucosal hemorrhages at 5 to 7 o'clock which may raise concern for trauma (accidental or sexual abuse).



(With permission from Jonathan Thackeray, Nationwide Children's Hospital)

What laboratory tests should be performed if you are concerned about sexual abuse?

- The presence of a sexually transmitted infection (STI) is used by physicians, social service agencies, and the criminal justice system as a means of identifying children who may have been sexually abused.
- STIs are uncommon in asymptomatic children and occur in only <10% of sexually abused children. If the rates of STIs in the local adult community are high, the child is more likely to acquire a STI.
- Some STIs have a long incubation period and/or an asymptomatic carriage rate, which may lead to a delay in presentation. The most likely STIs to be encountered clinically are: human papilloma virus (presenting as warts), *Neisseria gonorrhoeae*, *Chlamydia trachomatis*, herpes simplex virus, syphilis, and Human Immunodeficiency Virus (HIV).
- Because positive tests for STIs are uncommon in asymptomatic prepubertal children, selective testing is appropriate.
- Consider testing for sexually transmitted diseases when a child discloses genital-genital, oral-genital, or anogenital contact; if you see an anogenital discharge, bleeding, or another abnormality on physical exam; or if the child discloses sexual contact with a person who has a history of an STI.
- Any child who is found to have one STI should be tested for others (e.g., genital warts should trigger testing for syphilis, etc.).
- Adolescent victims should be tested and treated for STIs in cases of acute sexual assault even if they are asymptomatic because of the high risk of infection. The NAATs are extremely sensitive and may be positive because of previously acquired infections or because of new exposure to fluid with STIs. Clinicians should be aware that some ER protocols suggest against STI testing in adolescent victims. Positive results in cases being prosecuted may lead to discussion of the victim's past sexual history and

previous partners which may cause further trauma to the victim. However, STI testing can result in appropriate medical care and follow-up of the individual patient.

What are the current recommendations for STI testing?

When STI testing is performed during sexual abuse evaluations, the CDC recommends (see reference #5) the following:

- Cultures for *Neisseria gonorrhoeae* from the pharynx, anus, and vagina (urethra in males). Nucleic acid amplification tests (NAATs) for gonorrhea may be used instead of vaginal culture in assessing genital infection in girls. The CDC recommends cultures for *Chlamydia trachomatis* from the anus. NAATS for chlamydia can be used to screen for genital infection in girls. Any positive NAAT specimen in a pre-pubertal girl should be retained for further testing if needed.
- Cultures of any ulcerative lesions for herpes simplex virus (HSV), wet mount (culture, or NAAT if available) for *Trichomonas vaginalis*, and inspection of the anogenital and oral areas for human papillomavirus (HPV) are also recommended.
- Hepatitis B screen (if not immunized), serology for syphilis (RPR, VDRL) and HIV testing should also be considered. Factors that increase the risk of HIV transmission include vaginal or anal penetration, ejaculation on the mucous membranes, multiple perpetrators, a perpetrator who is a man who has sex with other men or who has a history of injected drug use, and mucosal trauma to either the patient or perpetrator. If the patient is at risk for HIV transmission, post exposure prophylaxis (short term anti-retroviral treatment to reduce the likelihood of HIV infection after potential exposure), should be discussed with the patient and caregiver. If PEP is being prescribed in a child, consultation with a specialist should be considered and PEP should be given as soon as possible within 72 hours of the assault (see reference #6).

Ask participants to turn to their packets and review Table 2: Implications of the Diagnosis of STIs for the Reporting of Sexual Abuse in Pre-pubertal Children, and Table 3: Frequency of STIs in 485 Girls 0-13 Years Evaluated for Sexual Abuse. Allow a few minutes for discussion.

TABLE 2. Implications of the Diagnosis of Sexually Transmitted Infections (STIs) for the Reporting of Sexual Abuse of Prepubertal Children

<i>STI confirmed</i>	<i>Sexual abuse</i>	<i>Suggested action</i>
Gonorrhea ^{a,b}	Diagnostic	Report ^c
Syphilis ^a	Diagnostic	Report ^c
HIV ^d	Diagnostic	Report ^c
<i>Chlamydia</i> ^{a,b}	Diagnostic	Report ^c
<i>Trichomonas vaginalis</i> ^a	Highly suspicious	Report ^c
Condylomata acuminata ^a (anogenital warts)	Suspicious	Report ^c
Genital herpes	Suspicious	Report ^{c,e}
Bacterial vaginosis	Inconclusive	Medical follow-up

^a If not perinatally acquired and rare nonsexual vertical transmission is excluded.

^b Culture and/or nucleic acid amplification tests should be confirmed.

^c To agency mandated in state or community to receive reports of suspected sexual abuse.

^d If not perinatally or transfusion acquired.

^e Unless clear history of autoinoculation.

Data from Centers for Disease Control and Prevention. STD treatment guidelines 2010. *MMWR* 2010;59[RR-12]:93; and Kellogg N, the American Academy of Pediatrics Committee on Child Abuse and Neglect. The evaluation of sexual abuse in children *Pediatrics* 2005;116:506–512.

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TABLE 3. Frequency of STIs in 485 Girls 0-13 Years Evaluated For Sexual Abuse

<i>STI</i>	<i>Frequency (%)</i>
Gonorrhea	3.3
<i>Chlamydia</i>	3.1
<i>Trichomonas vaginalis</i>	5.9
Syphilis	0.3
HIV	0
Genital herpes	1

Data from Girardet R, Lahoti S, Howard L, et al. Epidemiology of sexually transmitted infections in suspected child victims of sexual assault. *Pediatrics* 2009;124:79-86. Note that only a small number of boys enrolled, none were found to have an STI

Think back to the case involving Margaret. What further steps are indicated at this point?

- A careful interview is essential. This can best be performed by a clinician with special training in forensic interview techniques with children. Forensic interviewers may be medical social workers, mental health professionals, members of child protective services, or law enforcement detectives. Many forensic interviewers work in child advocacy centers which specialize in the multidisciplinary evaluation of children who are suspected of having been sexually abused.
- A child may disclose sexual abuse during the course of a routine history or physical examination. Should this happen, carefully record the child's disclosure in his or her own words and note whether the disclosure was made spontaneously. You may play an important role as the first professional to hear the child's disclosure of abuse. The medical provider's role in reporting what a child says has a legal stature and is an exception to the hearsay rule in most states.
- After an initial disclosure, clinicians may want to consider the following questions while taking a history for the purpose of medical diagnosis and treatment: "Do you know why you are here today?" "Can you tell me what happened?" "How did it begin? What happened next?" "Did anything change? Where?" "Where was everyone else?" "Why tell now? Has anybody told you to keep it a secret?" "Have you been hurt?" "And then what happened?" "What were you wearing?" "What did the room look like?" Older children and adolescents may be aware of whether ejaculation occurred. Remember that the first report may not be the first incident.
- Clinicians must carefully record in the medical record the wording of each question asked, and the child's specific response. Special care should be taken when abuse allegations occur in the context of a child custody case or divorce. It is generally recommended that the clinician not interview the child by him or herself, as the disclosure interview is best conducted by the most experienced professional possible.

What are a clinician's reporting obligations if sexual abuse is suspected?

- If you suspect sexual abuse, you need to file a report on the child's behalf with your local child protective services agency. All clinicians in the United States are required under the laws of each state to report cases of known or suspected child abuse. Failure to report can result in potential prosecution. Statutes generally provide immunity from lawsuits when reports are subsequently unsubstantiated, provided that they were made in good faith.
- Once a report is filed, child protective services and law enforcement personnel conduct an investigation that usually includes interviews of the child and all pertinent adults. Often a referral will be made for the child and family to receive supportive

psychological counseling after the investigation is complete. In Margaret's case, you will probably need more information before filing.

Distribute Part III and ask someone to read it aloud.

PART III

Epilogue:

You refer Margaret and her family for a forensic interview at a local child advocacy center. During the interview, she discloses that her Uncle Bob “*put his finger in my pee-pee and it hurt. He told me it was our secret and not to tell. I don’t like him.*” A report of suspected child sexual abuse is filed on Margaret's behalf and the case is subsequently referred to the District Attorney's office. As part of the safety plan put into place by CPS, visits with child's uncle are stopped. Margaret is referred for longer term counseling, and her behavioral symptoms gradually resolve.

You see her back at a follow-up visit in 6 weeks and she appears to be doing well. Her enuresis has resolved.

Refer back to group's learning agenda and summarize the key teaching points that were made. This will give the group a sense of accomplishment, and emphasize the important messages. Suggest further sources of reading or other information if there are agenda items that were not covered in the discussion.

Clinical Pearls:

- Many signs and symptoms of child sexual abuse are non-specific and can be seen in other medical or behavioral disorders.
- The ano-genital exam in victims of child sexual abuse is usually normal
- The child's clear statement that he or she has been abused is usually the best evidence that abuse has occurred. Unless there are specific signs or symptoms or a recent (<1 week) episode that needs to be evaluated, the forensic history should be obtained first before the physical examination.
- Prepubertal victims of sexual abuse should be selectively screened for STIs. In contrast, universal screening of adolescents is recommended given the high rates of consensual sexual activity and asymptomatic infection.

Knowledge questions:

Ask learners to complete the knowledge questions in their packet. If time allows, questions and answers can be discussed as a group, or learners can complete and review answers on their own.

1. *Which of the following is an important reason for performing an ano-genital examination in suspected victims of sexual abuse?*
 - a. Document injuries
 - b. Perform STI screening if indicated
 - c. Reassure child that (s)he is not physically “damaged”
 - d. All of the above

2. *Consider testing a pre-pubertal child for STIs when which of the following criteria are met?*
 - a. Physical exam shows signs of an STI or there is an ano-genital injury
 - b. Child discloses contact with alleged perpetrator's genitalia
 - c. All of the above
 - d. None of the above
3. *What is usually the best evidence that child sexual abuse has occurred?*
 - a. Physical exam findings
 - b. DNA evidence
 - c. Videotape of the abuse
 - d. Child's clear statement
4. *True or False?*

If a child gives consent to sexual contact with an adult, it is not sexual abuse.

Answers to knowledge questions:

1. *Which of the following is an important reason for performing an ano-genital examination in suspected victims of sexual abuse?*

Preferred response: D "All of the above."

Most victims of sexual abuse have normal exams. The purpose of the medical exam is to document injuries if present, screen for STIs if indicated, and in cases where the exam is normal, reassure the patient and family that the child's body is normal and healthy. Many survivors of sexual abuse worry that they are "damaged goods" and a normal exam can be a tremendous relief to the child and family.
2. *Consider testing a pre-pubertal child for STIs when which of the following criteria are met?*

Preferred response: C "All of the above."

The prevalence of STIs in children who have been sexually abused is low (<10%). Selective screening for STIs in pre-pubertal victims of child sexual abuse is recommended. Criteria for screening include a disclosure of contact with the perpetrator's genitals, a perpetrator with a known STI, signs of penetrating injury or an STI, and a sibling or other child in the household with an STI.
3. *What is usually the best evidence that child sexual abuse has occurred?*

Preferred response: D "Child's clear statement."

Evidence of penetrating ano-genital trauma is uncommon in child sexual abuse. When it occurs it can be helpful in moving the case forward in criminal court. However, most cases of child sexual abuse have normal ano-genital exams. Therefore, the child's statement that sexual contact occurred is usually the best evidence of abuse. A detailed interview of the child should occur with a professional trained in forensic interview techniques so that open ended, non-leading, developmentally appropriate questions are asked. When a child describes in detail sexual activities that are above and beyond their developmental level, it can be very compelling to professionals in child protection and law enforcement, as well as to juries in the criminal court system.
4. *True or False?*

Preferred response: False.

Children by virtue of their age and developmental level are not able to give consent for sexual activity. The age at which an individual can consent to sexual activity varies by state. In some states, the age of consent is 16 years, provided the sexual activity is not with an individual in a position of authority and the teen does not have cognitive or other impairments. Medical providers should be familiar with the laws of their state. (See Child Welfare Information Gateway. State statutes: searchable online database. Available at : www.childwelfare.gov/systemwide/laws_policies/state. Accessed: April 9, 2012)

References:

1. Adams J. Medical evaluation of suspected child sexual abuse: 2009 update. *APSAC Advisor*. 2010;22:2-7.
2. Adams J, Harper K, Knudson S, et al. Examination findings in legally confirmed child sexual abuse: it's normal to be normal. *Pediatrics*. 1994;94:310-17.
3. Adams J, Knudson S. Genital findings in adolescent girls referred for suspected abuse. *Pediatr Adolesc Med*. 1996;150:850-7.
4. Berkoff M, Zolotor A, Makoroff K, et al. Has this prepubertal girl been sexually abused? *JAMA*. 2008;300:2779-92.
5. Centers for Disease Control and Prevention. STD treatment guidelines 2010. *MMWR* 2010;59(RR-12).
6. Centers for Disease Control and Prevention. Antiretroviral postexposure prophylaxis after sexual, injection drug use, or other nonoccupational exposure to HIV in the United States. Recommendations for the US Department of Health and Human Services. *MMWR* 2005;54:(RR-2).
7. Finkel M. Medical aspects of pre-pubertal sexual abuse, in Reece R, Christian C (eds). Child abuse (ed 3). Elk Grove Village, IL, American Academy of Pediatrics, 2009, pp 269-319.
8. Girardet R, Lahoti S, Howard L, et al. Epidemiology of sexually transmitted infections in suspected child victims of sexual assault. *Pediatrics*. 2009;124:79.
9. Heger A, Muram D, Emans SJ. *Evaluation of the Sexually Abused Child*, Second edition. New York: Oxford University Press; 2000.
10. Heger A, Ticson L, Velasquez O, et al. Children referred for possible sexual abuse: medical findings in 2384 children. *Child Abuse Negl*. 2002;26:645-59
11. Kellogg N and the American Academy of Pediatrics Committee on Child Abuse and Neglect. The evaluation of sexual abuse in children. *Pediatrics*. 2005;116:506-12.
12. Leder, M.R., Emans, S.J.: Sexual Abuse in the Child and Adolescent in Emans, S.J., Laufer, M.R. (eds). *Pediatric and Adolescent Gynecology*, ed 6, Philadelphia, Lippincott, Williams and Wilkins, 2012.
13. Muram D. Classification of genital findings in prepubertal girls who are victims of sexual abuse. *Adolesc Pediatr Gynecol*. 1988;1:149-51.

Recommended CD ROMS

- Lowen D, Reece R, the American Academy of Pediatrics. *Visual diagnosis of child abuse*, CD-ROM, 3rd ed., 2008.
- Muram D, Harrison L, Adams J, eds. North American Society for Pediatric and Adolescent Gynecology CD-ROM: *Sexual abuse: medical evaluation for the primary care physician*, 2002.

Materials for Learners:

Packet should include the following:

- Handout #1: External Genital anatomy in a pre-pubertal child (Figure 1 with labels)

- Handout #2: Classification of Ano-genital Findings in Children with Suspected Sexual Abuse (Table 1)
- Handout #3:
 - Implications of the Diagnosis of STIs for the Reporting of Sexual Abuse in Pre-pubertal Children (Table 2)
 - Frequency of STIs in 485 Girls 0-13 Years Evaluated for Sexual Abuse (Table 3)
- Clinical pearls
- Knowledge questions and answers
- References/Recommended material

Margaret's Secret

Sexual Abuse

Part I:

Introduction:

Margaret is a 5-year old girl who comes to your office for evaluation of genital discomfort and bedwetting.

Current History:

Her mother has noticed irritation and redness of Margaret's vulvar area during the last week and that she has been wetting the bed for the past two weeks after having been fully toilet trained. She tells you that Margaret has had no vaginal discharge or bleeding, and has otherwise been healthy.

Mother denies that Margaret has any urinary frequency, urgency, or day time wetting. She reports some dysuria. When you ask if there have been any changes in child's behavior, Margaret's mother appears distressed and she asks to speak to you alone. Margaret is reluctant to leave the room without her mother but finally accompanies your assistant to the play area.

Mother tells you that, for the past week, Margaret has seemed unusually anxious. She has been reluctant to separate. The teacher reported that Margaret seems withdrawn, and somewhat hesitant about joining in activities that used to be her favorites. You find out that the family returned two weeks ago from a visit with Margaret's aunt and uncle. Three days into the visit, Margaret refused to stay alone with her uncle stating to her mother that "*I don't like Uncle Bob.*" Margaret's mother found these statements concerning but when she asked further questions, Margaret refused to elaborate.

Past Medical History:

You check back in your notes and find that up to this point, Margaret's behavior and development have been entirely normal.

Margaret's Secret

Sexual Abuse

Part II

Next Steps:

Additional History:

Margaret's mother denies that Margaret has been using any new soaps, bubble baths, or lotions. Margaret has never had prior urinary tract infections. There have been no recent psychosocial stressors in the home. Up to this point, Margaret had been doing well at school. There have been no changes in Margaret's appetite, but she has recently had problems falling asleep.

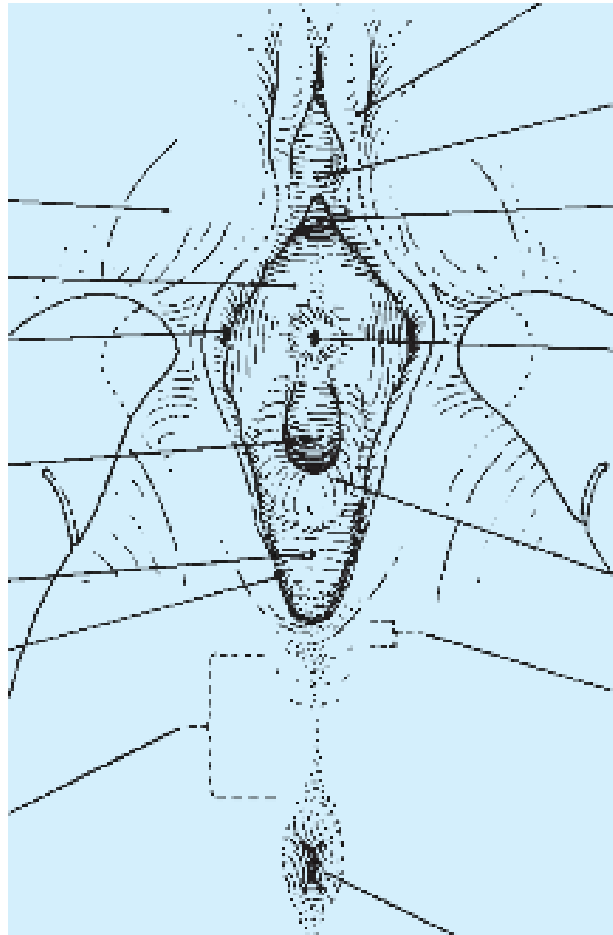
Physical Exam:

You find Margaret in the playroom and invite her back into the exam room. As you re-enter the room, your nurse informs you that Margaret's urine is negative for leukocyte esterase, nitrites, and glucose. You have Margaret's mother sit next to her on the exam table. She tolerates the general physical examination well. The neurological examination is normal. Margaret becomes somewhat anxious during the genital exam. Margaret's anal area and hymen appear completely normal. She has slight vulvar erythema. No discharge is present. You end the exam just as Margaret begins to cry, "*I don't like people to touch me there.*"

Margaret's Secret

Sexual Abuse

Figure 1 (without labels): External Genital anatomy in a pre-pubertal child



- Vaginal orifice
- Perineal body
- Posterior fourchette
- Hymen
- Urethra
- Labia minora
- Labia majora
- Anterior vestibulum
- Posterior vestibulum
- Mons pubis
- Anus
- Clitoral hood
- Clitoris
- Hart's line

Margaret's Secret

Sexual Abuse

Figure 2A



Figure 2B



(Figures 2A with permission from S.J. Emans and M.R. Laufer, *Emans, Laufer, Goldstein's Pediatric and Adolescent Gynecology*, 6th ed. Lippincott, Williams & Wilkins; Wolters Kluwer, 2012; Figure 2B with permission from Jonathan Thackeray, Nationwide Children's Hospital)

Margaret's Secret

Sexual Abuse

Part III

Epilogue:

You refer Margaret and her family for a forensic interview at a local child advocacy center. During the interview, she discloses that her Uncle Bob *“put his finger in my pee-pee and it hurt. He told me it was our secret and not to tell. I don't like him.”* A report of suspected child sexual abuse is filed on Margaret's behalf and the case is subsequently referred to the District Attorney's office. As part of the safety plan put into place by CPS, visits with child's uncle are stopped. Margaret is referred for longer term counseling, and her behavioral symptoms gradually resolve.

You see her back at a follow-up visit in 6 weeks and she appears to be doing well. Her enuresis has resolved.