Practice Essentials

Sexual activities imposed on children represent an abuse of the caregiver's power over the child. The sequence of activities often progresses from noncontact to contact over a period of time during which the child's trust in the caregiver is misused and betrayed. Pediatricians are often in trusted relationships with patients and families and are in an ideal position to offer essential support to the child and family. Thus, pediatricians need to be knowledgeable about available community resources, such as consultants and referral centers for the evaluation and treatment of sexual maltreatment.

Essential update: New AAP guidelines on child sexual abuse

New guidelines regarding child sexual abuse were issued by the American Academy of Pediatrics (AAP) in July 2013. They provide recommendations such as how to talk to parents, how to interview children, what to include in the medical record, what to cover during a physical examination of the child, when tests should be ordered, and how to protect the child’s mental and emotional well-being.[79, 80]

The guidelines enumerate 5 important issues that must be resolved when the issue of possible child sexual abuse arises during an office visit:

- The pediatrician must determine whether the child is at any risk for additional harm if he or she returns home; if the child may be put at risk, this constitutes a child protection emergency, and child protective services or law enforcement should be contacted at once
- In the absence of imminent risk, the physician must determine if there is evidence of suspected abuse that would require him or her to contact law enforcement or child protection
- The pediatrician should assess the child for possible mental health problems and seek emergency mental health care for the child, who may suffer posttraumatic stress disorder (PTSD) and depression or who may be the focus of family anger because of the disclosure
- Pediatricians must perform a thorough physical examination to determine whether the child has been injured, though examination may be deferred if the suspected abuse was in the distant past and the child is without symptoms
- Finally, if the abuse was recent and involved exchange of bodily fluids, the child should be immediately referred to those capable of gathering forensic evidence, such as a specialty clinic or an emergency department; many states require that such evidence be collected if the suspected abuse occurred in the last 72 hours, though the rise of DNA testing may extend the value of forensic evidence even beyond 72 hours

Signs and symptoms

In incidents of CSA, the interview with the child is typically the most valuable component of the medical evaluation; the elicited history is frequently the only diagnostic information that is uncovered.

Elements of the history include the following:

- General approach that is developmentally sensitive (ie, age-appropriate)
- Initial introduction with efforts to build up trust (including both child and caregiver)

- Caregiver interview
- Child interview, focusing on asking simply worded, open-ended, nonleading questions
- Wrap-up and preparation for the physical examination

The general approach to the physical examination follows the standard head-to-toe approach. Elements of the examination include the following:

- Determination of structures of interest – Mons pubis, labia majora and minora, clitoris, urethral meatus, hymen, posterior fourchette, and fossa navicularis
- Choice of positioning for optimal exposure of prepubertal genital structures – Frog-leg supine position, knee-chest position, or left lateral decubitus position
- Calming the child during examination
- General observation and inspection of the anogenital area, looking for signs of injury or infection and noting the child's emotional status
- Visualization of the more recessed genital structures, using handheld magnification or colposcopy as necessary
- Collection of specimens for sexually transmitted disease (STD) screening and forensic evidence collection
- Evaluation of any observable findings – Although most individuals who have been sexually abused present with essentially normal examination findings, observable findings may include (1) those attributable to acute injury or (2) chronic findings that may be residual effects following repeated episodes of genital contact

The Muram diagnostic categorization system classifies prepubertal genital examination findings as follows:

- Category I - Genitalia with no observable abnormalities
- Category II - Nonspecific findings that are minimally suggestive of sexual abuse but also may be caused by other etiologies
- Category III - Strongly suggestive findings that have a high likelihood of being caused by sexual abuse
- Category IV - Definitive findings that have no possible cause other than sexual contact (eg, seminal products in a prepubertal female child's vagina, the presence of a nonvertically transmitted gonorrhea or syphilis infection)

Another classification system, developed by Adams et al on the basis of the Muram approach combined with information from other components of the sexual abuse assessment, includes the following 8 categories of findings[13, 14] :

- Findings documented in newborns or commonly seen in nonabused children (ie, normal variants)
- Findings commonly caused by other medical conditions
- Indeterminate findings (ie, insufficient/conflicting research data require caution in interpretation)
- Findings diagnostic of trauma and/or sexual contact
- Residual or healing injuries
- Injuries of blunt force penetrating trauma
- Infection that confirms mucosal contact with infected bodily secretions (ie, indicating that contact was most likely sexual)
- Findings diagnostic of sexual contact (ie, pregnancy or sperm directly taken from a child's body)

See Presentation for more detail.

Diagnosis

[#WorkupHistologicFindings] Cultures are the criterion standard and are valuable from a forensic evidence standpoint. Depending on the situation, testing may include the following:

- Gram stain of vaginal or anal discharge
- Genital, anal, and pharyngeal culture for gonorrhea
- Genital and anal culture for chlamydia
- Serology for syphilis
- Wet prep of vaginal discharge for *Trichomonas vaginalis*
- Culture of lesions for herpes virus
- Serology for HIV (based on suspected risk)

Other tests that may be considered include the following:

- Collection of forensic evidence via rape kit

- Urine toxicology screen (if the abuse or assault was substance-facilitated)

See Workup for more detail.

Management

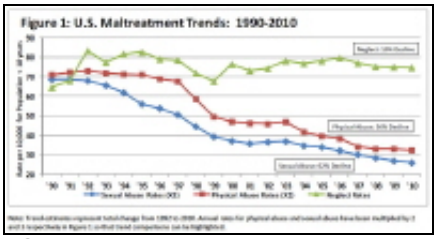
Medical treatment of CSA is guided by any conditions uncovered. Recommendations include the following:

- Treat STDs with appropriate medications
- In postmenarchal children, consider the possibility of pregnancy
- Recognize the overriding need for emotional support and attention
- When sexual abuse is seriously suspected or has been diagnosed, ensure that it is reported to the appropriate child protective services (CPS) agency
- When sexual abuse is being considered, consider reporting it, depending on the perceived risk to the child
- Keep well-documented medical records; legal proceedings may occur over long periods, and the health care provider cannot rely solely on memory

Mental health consultation is warranted to evaluate and treat acute stress reaction and, later, posttraumatic stress disorder (PTSD).

See Treatment and Medication for more detail.

Image library



US maltreatment trends, 1990-2010.

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Disclosure: Bayer Honoraria Review panel membership; Pfizer Grant/research funds Independent contractor; MedImmune Honoraria Review panel membership; Teva Pharmacutical travel & honoraria Managed Care Advisory Panel; CIGNA Honoraria Physician Advisory Council

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Disclosure: Nothing to disclose.

Additional Contributors
The authors acknowledge the consistent support and mentorship by Carol D Berkowitz who, despite multiple clinical, teaching, and administrative responsibilities, has found the time to share her considerable expertise and even took the time out of her busy schedule to provide the photographs used to illustrate the physical findings possible when evaluating cases of suspected child sexual abuse. Dr. Berkowitz exemplifies the characteristics of a committed medical educator who is not limited by organizational or geographic boundaries.

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