Child Sexual Abuse

Background
1. Definition:
   - Any sexual activity with a child before the age of legal consent 17-18 (depending on the state) - by an adult or substantially older child
   - Contact activities:
     - Oral-genital
     - Genital-genital
     - Genital-rectal
     - Hand-genital
     - Hand-rectal
     - Hand-breast contact
   - Non-contact activities:
     - Exposure or forced viewing of sexual body parts, showing or using a child in pornography
2. General info
   - Physicians are required, in all 50 states, to report cases of confirmed or suspected sexual abuse
   - Up to 80,000 cases per year reported
   - Number of unreported cases presumed to be much higher

Pathophysiology
1. Incidence, prevalence
   - In 2000, 879,000 children spanning 34 reporting states (accounting for 78.1% of the US child population) were estimated to have been maltreated
   - 88,000 of those 879,000 (10.1%) were cases of sexual abuse
   - Estimated overall lifetime incidence worldwide is 11-32% for females and 4-14% for males, not including ritualistic practices such as male or female circumcision
   - Accuracy of statistics dubious due to reporting biases
2. Risk factors
   - Opportunistic settings
     - Playgrounds, family gatherings, or near abuser's home, higher crime areas, group homes, care givers
   - Child with developmental delay
   - Inebriation of or substance use / abuse by child
   - Inebriation of or substance use / abuse of caregiver(s)
   - Inadequate supervision
3. Morbidity/ mortality
   - Long term sequelae can lead to low self-esteem with increased incidence of depression, suicide, becoming a future sexual abuser / predator, and emotional detachment
   - Abnormal or distorted views of sex, seductiveness, prostitution
   - Depression and other psychopathology, withdrawal from society, mistrust of others, suicidal ideation, secretiveness
   - Sleep problems/ nightmares
**Diagnosis**

1. **History**
   - Include child's exact words in your documentation
   - Consider referral to forensic pediatrician or child protective services for formal interview and PE
   - If possible, videotape and / or tape record the history
   - A detailed medical and social history is very important.
   - Use open-ended questions in a friendly area that is free from distractions
   - Use simple language
   - Who, What, When, Where, How and How often? (Best to perform interview in a safe and friendly environment with the child alone [away from other family members])
   - Detailed history from caregiver
     - Why sexual abuse is suspected
     - To whom the child made the disclosure and under what circumstances
     - What the child said
     - Changes noted in the child's behavior
     - Medical concerns (pain, discharge, bleeding)
     - How the child verbally refers to their genitalia
     - Who lives with the child at home and who the caregiver(s) is / are
     - PMH
     - Detailed family and social histories

2. **Physical exam**
   - Often there are no physical signs of sexual abuse (<10% of cases)
   - Complete head-to-toe PE; explain what you will be doing before you do it and explain why it is necessary
   - Photo documentation of all abnormalities
   - Focus on:
     - Skin marks / bruising
     - Oral exam
     - GU exam
     - Anal / rectal exam
   - If <72 hrs after reported incident: urgent exam, use sexual assault kit (usually at ER or child advocacy center)
   - If >72 hrs after reported incident, schedule exam at child advocacy center or other specialized center in near future; ensure child in safe setting until this scheduled exam
   - Must recognize normal from abnormal anatomy (especially when examining the hymen)
   - In pre-pubertal females, a speculum exam (when needed) is ideally performed under sedation
   - Fissures of anus can be caused by large, hard stools
   - Colposcopy recommended for females for evaluation and photo-documentation

3. **Diagnostic testing**
   - Laboratory evaluation
     - GC & Chlamydia cultures (rather than DNA probes)
     - Vaginal, oral and rectal swabs (looking for semen, hair, DNA, or other evidence of perpetrator having had sexual contact with patient)
- RPR, HIV (at 0 and 3 month f/u visit), Hepatitis B & C
  - Diagnostic imaging
    - Colposcopy (with recorded video imaging)

**Differential Diagnosis**

1. Key DDx
   - Accidental injury
   - Self-inflicted injury
   - Straddle injury
   - Local infection
     - Cellulitis, abscess, molluscum, pinworms
   - Local rash
     - Dermatitis, monilia
   - Nonspecific or chemical vulvovaginitis

2. Extensive DDx
   - Genital warts
   - Consensual sexual contact
   - Normal childhood play/exploration
   - Masturbation
   - Munchausen by proxy
   - Parental conflict
     - Divorce and custody issues
   - Impaling injury
   - Lichen sclerosus
   - Lichen simplex chronicus
   - Lichen planus
   - Psoriasis
   - Bullous pemphigoid
   - Behcet's disease
   - Perineal hemangiomas
   - Hemorrhoid
   - Rectal prolapse
   - Distal urethral prolapse

**Therapeutics**

1. Acute treatment
   - Physician's role is to ensure that the abused child is protected, and receives the appropriate therapy
   - See child as soon as possible
   - Document everything (visual and auditory documentation is helpful)
   - Contact child protective services on all confirmed and suspected cases of child abuse without delay
   - Consider antibiotic prophylaxis to cover potential STIs
   - Consider "morning after" pill
   - Hepatitis B vaccination

2. Further management (24 hrs)
   - Call / ensure follow-up with child protective services
   - Ensure child will be protected
   - Check on patient's and caregivers' well being
- Ensure all evidence and documentation is forwarded to CPS and local law enforcement with chain of custody documented
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3. Long-term care
   - Referral to counseling
   - Referral to support group
   - Watch for low self esteem, feelings of worthlessness/ hopelessness

Follow-Up
1. Return to office
   - Follow-up closely and routinely to ensure that all lab results are either negative or acted upon, and to ensure that patient is coping adequately
2. Refer to specialist
   - Forensic pediatrician and/or child protective services should be consulted as early as possible
   - It is recommended that a multidisciplinary approach be used
3. Admit to hospital
   - Only if medically necessary or necessary for patient safety

Prognosis
1. Related to sex and age of the victim, their cultural /religious beliefs, and if the perpetrator was related to the victim or was in some other position of trust by the victim

Prevention
1. Parents should talk to their children and let them know that if someone is trying to touch their body or make them do things that make them feel strange, that they should say "NO" and immediately report this to another adult
2. Screening for child abuse beginning in pregnancy and continuing throughout childhood
   - Questions should focus on parent's own history of being abused and then questioning child about potential inappropriate acts by others
3. Screen what children watch on TV and over the internet
4. Ensure children are well-supervised when parent / primary caregiver is not present
5. Research the location of sex offenders in their neighborhood

References

**Author:** Sandra L. Worrell, MD, *Hinsdale FMR, IL*

**Editor:** Perry Brown, MD, *Idaho State University FPR*