Understanding and Responding to Suspected Child Sexual Abuse: the role of primary care: part 2

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Disclosure

• Neither I nor any member of my immediate family has a financial relationship or interest with any proprietary entity producing health care goods or services related to the content of this CME activity.

• I do not intend to discuss an unapproved/investigative use of commercial products/devices.
Learning Objectives

Participants will learn an approach to medical evaluation of child sexual abuse that is diagnostic and therapeutic.

Participants will learn how to conduct ano-genital exams and interpret residual to alleged sexual contact.

Participants will learn to formulate a balanced, objective and defensible diagnostic assessment.
Examining the Child Victim

- Preliminaries
  - Obtain historical details of the alleged events
  - Clarify additional information to be obtained
  - Develop rapport and trust of child
  - Explain the purpose of the examination
  - Tell the child what will happen
  - Determine the child’s names for body parts
  - Encourage the child to ask questions
  - Assess the cooperativeness of the child
  - Child selects adult ally to be present during the examination
  - Encourage child to participate in “head to toe “ examination
Immediate Examination: Criteria

- Age inappropriate sexual contact within 72 hours
- Genital trauma within 72 hours
- Possibility of a sexually transmitted disease
- Possibility of pregnancy


Deferred examination criteria

- Disclosure of age inappropriate sexual contact greater than 72 hours
- *Uncooperative child*
Examination room
Head to toe examination
Who is this Greek God?
Hymen

Factoid:
• Children are born without hymens
• Children lose their hymens
• Hymens are injured during gymnastic and horseback riding

Fact:
• All children are born with hymens except in rare congenital disorders
  • Ambiguous genitalia
  • Distal vaginal agenesis
  • Transverse vaginal septum
“Total absence of hymen, reports of which are found in the older literature, has not been observed by modern authors, while not denying the possibility consider this phenomenon exceedingly rare”

G. Gelhorn, American Journal of Obstetrics and Diseases of Women and Children, 1904

“To say that this delicate piece of membrane is from the non-physical point of view a more important structure than any other part of the body is to convey but a feeble idea of the importance of the hymen in the eyes of the men of many past ages and even of our own times and amongst our own people”

Ellis, Erotic Symbolism, 1912
Factoid:

- The transverse hymenal orifice diameter is valuable as a sole indicator of sexual abuse.

Fact:

- The transverse hymenal orifice diameter has minimal utility in making the diagnosis of child sexual abuse. Early studies by Cantwell that suggested a measurement > 4 mm as predictive has not been born out in further studies.

Medical examination findings

Factoid:

• The medical examination is frequently diagnostic of sexual abuse

Fact:

• The medical examination confirms sexual abuse in less than 5% of cases

• The medical examination rarely differs from that of the non-abused child


Eliciting idiosyncratic historical details

- Eliciting signs and symptoms that reflect residual to sexual contact
Symptoms and Signs

- **Girls**
  - 60% described ≥1 symptoms / signs
    - 53% genital pain
    - 37% dysuria
    - 11% bleeding

- **Caregivers**
  - sx / signs
    - 17% genital pain
    - 19% dysuria
    - 4% bleeding
  - 24% sought medical care (n=38)
    - 12% during abuse period (n=19)
Female Genital anatomy
Female Genital anatomy
Examination techniques
Normal genital anatomy: prepubertal
Normal genital anatomy: prepubertal
Normal Genital Anatomy: pubertal
Normal Genital Anatomy: positional variability
IN or ON:
Reconciling discrepancies

Determining the child's perception of their experience
  – use of Ortho anatomic model
Addressing any discrepancy between child's perception and their examination findings
  – educating the judge and jury


Eliciting idiosyncratic historical details

- Determining the child's perception of their experience
  - use of Ortho anatomic model
IN or ON: Reconciling discrepancies

Finkel MA, Physical Examination in; Finkel MA, Giardino AP, eds; Medical Evaluation of Child Sexual Abuse; a practical guide, 2009; pp.53-97, American Academy of Pediatrics, Chicago, Il.
Clinical Issue: Penetration - Genital
Healing of ano-genital trauma

Classic Signs of Trauma in Vulvar Coitus
Clinical issue: Determination of Virginity

Factoid:
- Women have bleeding with first intercourse
- A physician can tell with certainty if a woman is a virgin

Fact:

<table>
<thead>
<tr>
<th>Bleeding with first intercourse</th>
<th>Pain with first intercourse</th>
</tr>
</thead>
<tbody>
<tr>
<td>None 44%</td>
<td>None 32%</td>
</tr>
<tr>
<td>Slight 35%</td>
<td>Slight 22%</td>
</tr>
<tr>
<td>Moderate 9%</td>
<td>Moderate 15%</td>
</tr>
<tr>
<td>Heavy 12%</td>
<td>Severe 31%</td>
</tr>
</tbody>
</table>

Dilation of Anal Sphincter with Downward Pressure by Convex Side of Penis

Finkel MA, Giardino AP, eds; Medical Evaluation of Child Sexual Abuse; a practical guide, 2009; pp.53-97, American Academy of Pediatrics, Chicago, Il.
Healing of ano-genital trauma

- Retrospective interpretation of changes in anogenital anatomy
- Understanding healing chronology of acute trauma
- Regeneration of labile cells without residual
- Repair results in formation of granulation tissue -repair
- Appreciate limitations of retrospective interpretation


Healing of ano-genital trauma

Day 1

4 5/12 y.o. with acute straddle/crush injury while playing on jungle gym

Day 3

Day 7
Acute injuries in 3 y.o at 4 magnification with transection extending onto perineum presenting on day 3 following penetrating trauma to the hymen extending to the base of attachment, fossa, fourchette and onto the perineum can be viewed.

Healed injury demonstrates clear interruption in the integrity of hymen membrane extending to the posterior vaginal wall. The finding is diagnostic of blunt penetrating trauma in absence of acute
Acute blunt force penetrating trauma to vaginal floor, hymen, fossa and fourchette in 23 m.o.

2 month follow-up examination demonstrates “key-hole” configuration to healed injuries
Healing of ano-genital trauma

19 m.o. 4 days Post Penetration

Healed residual 4 months post injury
Medical Diagnosis of Child Sexual Abuse:
Healing case study of regeneration of labile cells & repair

Acute blunt force penetrating trauma to vaginal floor, hymen, fossa and fourchette in 23 m.o.

2 month follow-up examination demonstrates “key-hole” configuration to healed injuries
Clinical Issue: Use of red Free Filter

Transactions Following Blunt Force Penetrating Trauma
Healed Genital Trauma
Healing of ano-genital trauma

Prolapsed edematous rectal tissue after surgical repair of complete transection of anal sphincter in 5 y.o. male

Appearance 6 days post repair with markedly reduced tissue edema and constriction of anal sphincter

Almost imperceptible scar tissue hidden in rugal fold at 11 o’clock position almost 1 year following surgical repairs illustrates how difficult it can be to retrospectively interpret healed residual.
Clinical Issue: Penetration - Anal

3 y.o male within 24 hours of sodomy with lacerations of anal verge tissue, bruising and tissue edema

Two month follow-up demonstrates marked decrease in swelling, resorption of bruising and normalization of anal anatomy with the exception of healed laceration at 6 o’clock
Clinical Issue: Penetration - Anal

Gluteal Cleft Abrasions – “Freaking”

- 273 children <10 years old
  - 24.9% examined within 44 hours of assault, 90% of positive results found within 24 hours following assault, no positive semen swabs after 9 hours
  - 64% of evidence when found retrieved from clothing/bedding, 35% of children had clothing/bedding collected


- 80 children (61%) & adolescents (39%) presenting within 72 hours of assault
  - 16 positive for semen (13 adolescents) all within 24 hours of assault
  - Seminal products recovered from 3 pre-pubertal children found only on clothing/bedding
Sexually Transmitted Diseases

- Those promiscuous fomites
  - toilet seats
  - wash cloths, bath water
  - bed linens
  - rectal thermometers, enema tips
  - caretakers hands

- Fomite transmission studies
  - Cooperman, 1927
  - Branch and Paxton, 1965
  - Shore and Winkelstein, 1971
  - Gilbaugh and Fuchs, 1979
  - Sgroi, 1979
  - Srivastara, 1981
  - Neinstein and Goldenring, 1984
Sexually Transmitted Diseases
Sexually Transmitted Diseases
Clinical Issue:
Accidental vs. inflicted patterns of trauma

Acute accidental trauma in 2 ½ y.o who fell on a rocking horse. Injury extends from fourchette to just above external anal verge tissue.

Classic unilateral accidental crush injury to labia and mons pubis area as a result of falling on a monkey bar in school playground.
Clinical Issue: Accidental vs. inflicted patterns of trauma

Vulvar hematoma from accidental penetrating trauma to the inner aspect of right labia minora.

Laceration of inner aspect of labia minora. Hematoma bulges tissue into vestibule obscuring hymen. With gentle displacement of hematoma hymen visualized and atraumatic.
Clinical Issue: Male Genital Trauma

Circumferential bite mark impressions with subcutaneous bruising and superficial abrasions. Child complained of dysuria.

Suction petechiae to glans in 4 y.o.
Clinical Issue: Male Genital Trauma

Bruising of glans in 3 y.o. due to pinching

3 y.o. with an acute laceration of dorsal aspect of penis at base secondary to being hit by a falling toilet seat.
Clinical Issue: Exrogenital Trauma

Fact:
- Exrogenital trauma is infrequently found in child sexual abuse
- Exrogenital trauma implies the use of force and restraint
- Exrogenital trauma most frequently manifested as:
  - Bite marks
  - Ligature marks
  - Grasp marks
  - Implement marks
What you need to know but too embarrassed too about formulating a diagnostic opinion in suspected CSA
Formulating a Defensible Diagnosis: basic tenets

• Objectively state the facts
• Do not exaggerate the meaning of a particular finding
• Know the limitations of what can be said
• Do not co-mingle hearsay and clinician obtained history when formulating a diagnosis
• State limitations
• Presume that diagnosis will be challenged
• Make sure that every statement is defensible and rests on sound scientific footings
Formulating a Diagnosis: basic tenets

• Utilize the diagnosis section to explain and educate those who will have access to the report
• Issues for which an explanation can be helpful
  – Why evidence does not exist when history of injury
  – Why evidence does not exist when child states that an object was placed inside them
  – How a child can acquire a sexually transmitted disease without genital to genital contact

Finkel MA. Putting it all together. J Child Sex Abuse. 2011;20:643-656
Medical history/behaviors are clear and descriptive of inappropriate sexual contact but no physical diagnostic residual is present.

Medical history/behaviors are clear and descriptive of inappropriate sexual contact with symptom-specific complaints reflective of genital and/or anal trauma.
Common Case Scenarios

- Medical history/behaviors are clear and descriptive of inappropriate sexual contact and physical diagnostic residual is present (i.e. acute/healed injuries, STD, other physical forensic evidence)

- Medical history/behaviors are suspicious and/or concerning that child either experienced something inappropriate and/or exposed to something inappropriate and the examination is without physical diagnostic residual.
Less Common Case Scenarios

• A child presents with a concern by a caretaker without historical or behavioral details to support the concern.

• A sexually transmitted disease is diagnosed in a young child, and no explanation for how the child contracted the disease is evident following a complete investigation.

• Upon examination, the clinician identifies a healed injury with no prior suspicion of abuse and for which no historical or behavioral indicators are presented.
• Witnessed inappropriate sexual interactions without physical diagnostic residual.

• Medical findings that mimic sexual abuse upon evaluation are found to be associated with medical conditions and not the result of abuse.

• Concerns arising in family with custody/visitation arrangements in young child requiring genital care.

• A child presents with fabricated or misinterpreted behaviors and/or a history alleging sexual abuse.
Diagnostic Conclusion Examples

• Medical history/behaviors are clear and descriptive of inappropriate sexual contact but no physical diagnostic residual is present.

The medical history presented by this 9 y.o. white female reflects her experiencing progressive engagement in a variety of inappropriate sexual activities initially represented to her in a caring and loving context and progressing to utilize treats. Although she did not complain of experiencing any physical discomfort following the genital fondling, oral genital contact or the touching of her uncles genitalia she has expressed a concern which merits attention. She told me that she was worried that she thinks that people can tell that she had to do those disgusting things just by the way that people look at her. She also provided historical details of contact with “icky stuff” coming from her uncles penis placing her at risk for contracting a sexually transmitted disease. I have evaluated her the possibility of such and will initiate treatment and follow-up should anything be positive.
Diagnostic Conclusion Examples

- Medical history/behaviors are clear and descriptive of inappropriate sexual contact but no physical diagnostic residual is present. cont...

Her physical examination does not demonstrate any acute or chronic residua to her sexual contact nor would be anticipated to in light of the her denial of discomfort associated with the contact. Her body image concern are common among children who experience sexual abuse. I do not believe there is any alternative explanation for this child’s history of progressive engagement in sexual activities, threats to maintain secrecy, detailed description of a variety of sexually explicit interactions and concerns about body image other than from experiencing such. The most significant impact of sexual victimization is psychological. She should be seen immediately by a clinical child psychologist to assess the impact of her sexual victimization and develop a therapeutic plan.
Diagnostic Conclusion Examples

- Medical history/behaviors are clear and descriptive of inappropriate sexual contact and physical diagnostic residual is present (i.e. acute/healed injuries, STD, other physical forensic evidence)

This 6 year old white female provided a clear and detailed history reflecting her experience of genital to genital contact and being coerced into placing her mouth on her fathers genitalia. The genital to genital contact was perceived by her to involve penetration into her vagina. She provided a history of bleeding and pain following the genital to genital contact. Although her disclosure of abuse occurred 1 month following the last contact her physical examination demonstrates residual to such in the form of a healed transection of the posterior portion of the hymen extending to the base of its attachment. Cont...
Diagnostic Conclusion Examples

- Medical history/behaviors are clear and descriptive of inappropriate sexual contact and physical diagnostic residual is present (i.e. acute/healed injuries, STD, other physical forensic evidence) cont...

This transection is diagnostic of the residual to the introduction of a foreign body through the structures of the vaginal vestibule, the hymenal orifice and into the vagina. She did not complain of physical discomfort associated with the history of oral genital contact although she stated that the alleged perpetrator peed in her mouth placing her at risk for a sexually transmitted disease.
Diagnostic Conclusion Examples

- Medical history/behaviors are clear and descriptive of inappropriate sexual contact with symptom-specific complaints reflective of genital and/or anal trauma.

This 5 y.o white female provided a detailed medical history reflecting genital to genital contact and discomfort associated with such. Although her perception of the genital to genital contact as demonstrated on an anatomic model of the genitalia involved penetration into her vagina, her examination indicates that any genital to genital contact that occurred was limited to penetration into the structures of the vaginal vestibule. Following the genital to genital contact she provided a history of discomfort in the form of dysuria. Her review of systems was negative for any alternative explanation for dysuria. The symptom of dysuria temporally related to the genital to genital contact reflects trauma to the periurethral area as a result of rubbing. The trauma incurred to the distal urethra was superficial and has since healed without residual as anticipated.
“The hymen has been reduced to only a ring surrounding the opening to the vagina. Through this hymenal remnant, one can visualize nonstratified epithelium within the vaginal canal. It has not yet cornified as would have occurred in somebody who was constantly being subjected to vaginal penetration. It would appear that this child has been subjected to penetration by some object greater than 1.0 cm in diameter, but less than 5.0 cm. On physical examination, physical findings of vaginal penetration consistent with digital penetration as opposed to penile penetration are found. These findings are within medical certainty and are based on the following:”

“Physical findings consistent within medical certainty of anal penetration are found. The basis for these conclusions are as follows: appearance of the vulva and perianal areas with erythema, fan shaped scarring, anal ruggae irregularities, lack of hymen etc. Based on the appearance of the vaginal orifice, it is doubtful that an erect male phallus was the instrument used to penetrate the vagina, although certainly an adult male finger could have caused the damages noted.”
Unbridled advocacy as heard in court...

“Did you see an intact hymen or did you not see an intact hymen or was there one or not one? “No there was definitely no hymen sir” Did you see this when you spread the labia apart? “I didn’t spread the big labia but he small labia you could not spread, they were fused together, they were scarred” But you were able to observe that there was no hymen? “Definitely. The cavity was right in front of me there was nothing obstructing it.”

“Didn’t you say that based on discoloration of the anus was what lead you to place the time frame as being 12 to 18 weeks, plus or minus 4 to 6 weeks, Are you now saying that the plus or minus was not related at all to the anus? “Actually, I wouldn’t even ... when I put 12 to 18 weeks I couldn’t choose to eradicate the plus or minus 4 to 6 weeks. I had to put it because I cannot come and say I’m God. I’m not God. When I put 12 to 18 weeks that’s is the time frame that I am really setting for that child”
Inappropriate medical conclusions

**PHYSICAL EXAMINATION cont’d**

With gentle lateral traction placed on the innermost thighs of this five-year-old young lady, the labia majora are stretched slightly, but not beyond physical tolerance. Once this maneuver is accomplished, it is noted that there is a normal degree and the external part is limited to an annular ring surrounding the entrance or vestibule of the vagina. On closer examination within the vagina, one notes stratified epithelium in circumferential arrangement throughout the vagina, signifying the physiological changes accompanying frequent menstruation beyond the normal ring. Small T-shaped scars are noted in the area of the posterior fourchette and throughout the vaginal vestibule. In addition, the median raphe stretching from the posterior vaginal vestibule to the anterior aspect is carried and excoriated. When one gets to the examination of the anus, it is noted that there are anal irregularities in the region and the amount of tension on the external anal sphincter. This loc. to this examiner's mind, leads to the conclusion of medical certainty that the anus has been penetrated on a frequent basis. As well, the examination then went on to other portions of the body.

The extremities are within normal limits with a full range of motion. There are no skin rashes noted. Except for the marked erythema in the area of the vaginal vestibule and the skin. The back is straight without evidence of kyphosis or scoliosis. No adenopathy is seen. All deep tendon reflexes are 2+ and equal and no abnormal superficial reflexes are seen. There is no palpable rigidity and the posture is said to be straight.

**NEUROLOGICAL EXAMINATION**

No formal neurological examination was undertaken at this time because of the nature of the complaint.

**CONCLUSIONS**

This is a 5-year-old male child with a given history of sexual abuse. On a full physical examination done on April 11, 1986, physical findings consistent with medical certainty of anal penetration and digital vaginal penetration are found. The basis for these conclusions are as follows: appearance of the vulva and perineal areas with meatus, frenula, scarred anal and mucosal irregularities, lack of hymen, etc. Based on the presence of the vaginal opening, it is doubtful that an erect male penis was the instrument used to penetrate the vagina, although certainly an adult male finger could have caused the damages noted.
Objectivity And Professionalism Translates Into Advocacy For Abused Children

Unbridled Advocacy Hurts Children
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