

Sexual Abuse / Assault Evaluation

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FOR THE PREVENTION AND TREATMENT
OF CHILD ABUSE AND NEGLECT



University of Colorado
Anschutz Medical Campus



Children's Hospital Color

Clinical Approach - Adolescent vs Child Exams

Big difference between care of the pre pubertal patient and the older patient.

Providers seeing pre pubertal patients should have some understanding of:

- Normal sexual development
- Anatomy
- Importance of history taking



Child Sexual Abuse ≠ Adult Sexual Assault

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Tanner Stage (Sexual Maturation)

≠

Cognitive Development

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Medical Protocol for Responding to Sexual Abuse

All children should be offered a timely exam

Purpose of medical exam:

- Identify
- Document
- Diagnose
- Prevent
- Treat medical conditions and/or trauma

Assess patient safety and well being



Medical Protocol for Responding to Sexual Abuse

Determine appropriateness of evidence collection and if needed collect biological trace materials

Exam should be therapeutic:

- Talk to child about body safety
- Discuss exam findings
- Answer questions that child/caregiver
- Discuss mental health and trauma responses to sexual abuse/assault



Medical History for Sexual Abuse

Complete history is taken:

- reason for evaluation,
- what's been done already, and
- context of the disclosure.

Details of any specific symptoms are considered, including hygiene, toileting, and enuresis/encopresis.

Behavior history is taken.

Ideally, a detailed social history is taken, including history prior maltreatment, exposure to sexually explicit material, and family attitudes around sexuality.



Information From the Patient

If child is young, information is obtained from caregiver without child present.

Forensic interviews are preferred.

Medical history focuses on details pertinent to the medical evaluation.



Disclosures

Delayed disclosures are common.

Young children have limited speech capacity

The relationship between child and perpetrator is unique

- The abuse may not be physically harmful

In the absence of a clear disclosure, other behavioral indicators may be very important



Questioning Children

Guidelines for Age-Appropriate Interview Questions							
Ages	WHO	WHAT	WHERE	WHEN	HOW	# OF TIMES	CHRONOLOGICAL NARRATIVE
2-3			Maybe				
4				Maybe			
5-6				Maybe			
7-9					Maybe		
10 and Up							

Key	
	Child <i>should</i> be able to answer these questions.
	Child <i>might</i> be able to answer these questions; interviewer should proceed with extreme caution.
	Child <i>will not</i> be able to answer these questions; therefore they should not be asked.

kids < 10 have difficulty w/ timelines

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(Courtesy of Jodi Byrnes, Denver Children's Advocacy Center)

Childhood Behaviors and Sexual Abuse

No single behavior is associated entirely with sexual abuse.

Developmentally incongruent behaviors are more strongly associated with sexual abuse or exposure to inappropriate sexual material.

Must distinguish between normal sexual behaviors and abnormal.

Problematic sexual behaviors – not necessarily from sexual abuse



Sexual Abuse Exam and Exam Techniques



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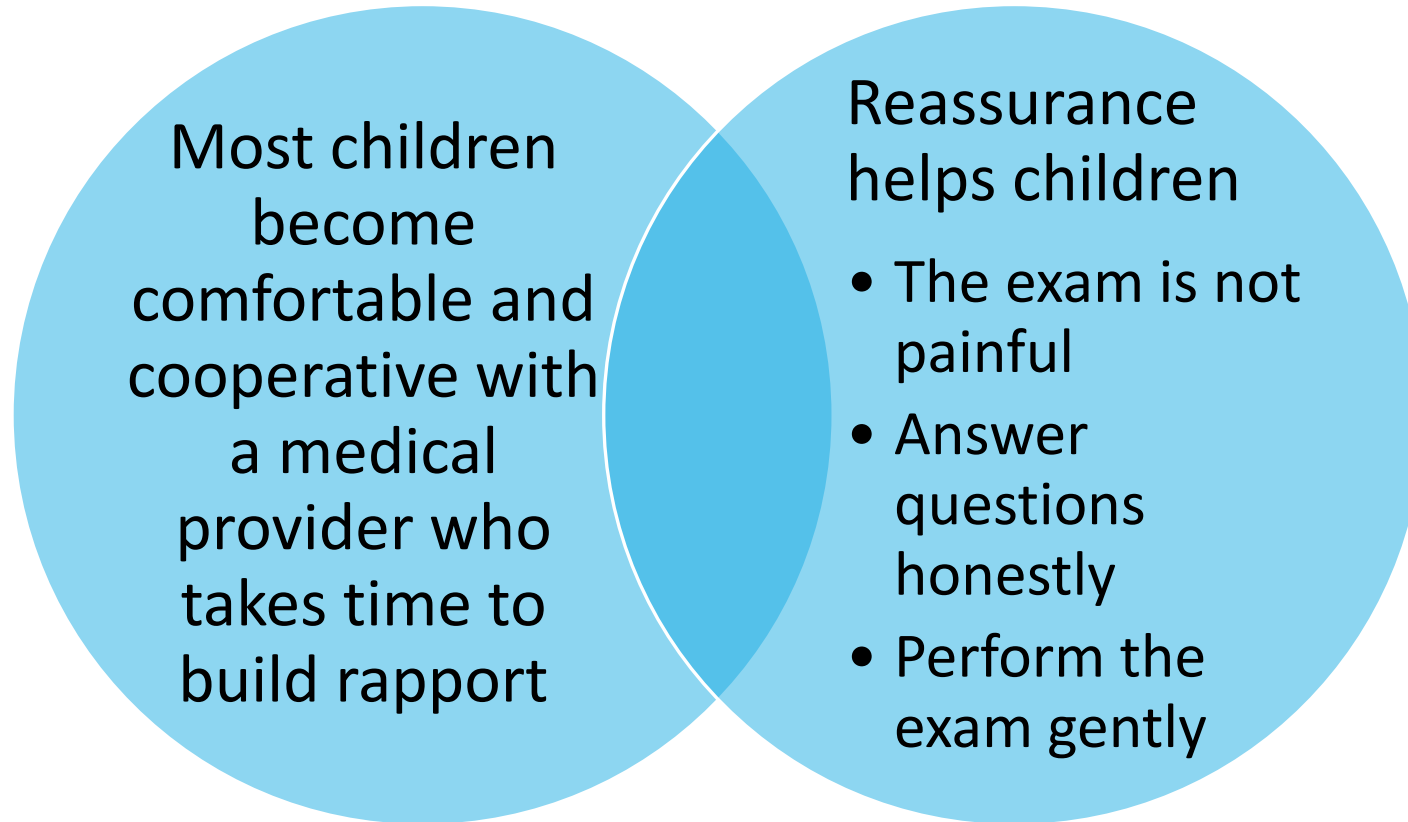
Physical Exam

Physical Exam

- Full head to toe exam (looking for other signs of abuse too)
- Usually non-invasive
- Fully explained to patient
- Patient is in position of control
- Exam position:
 - “Frog-leg”
 - On parent’s lap
 - Supine lithotomy



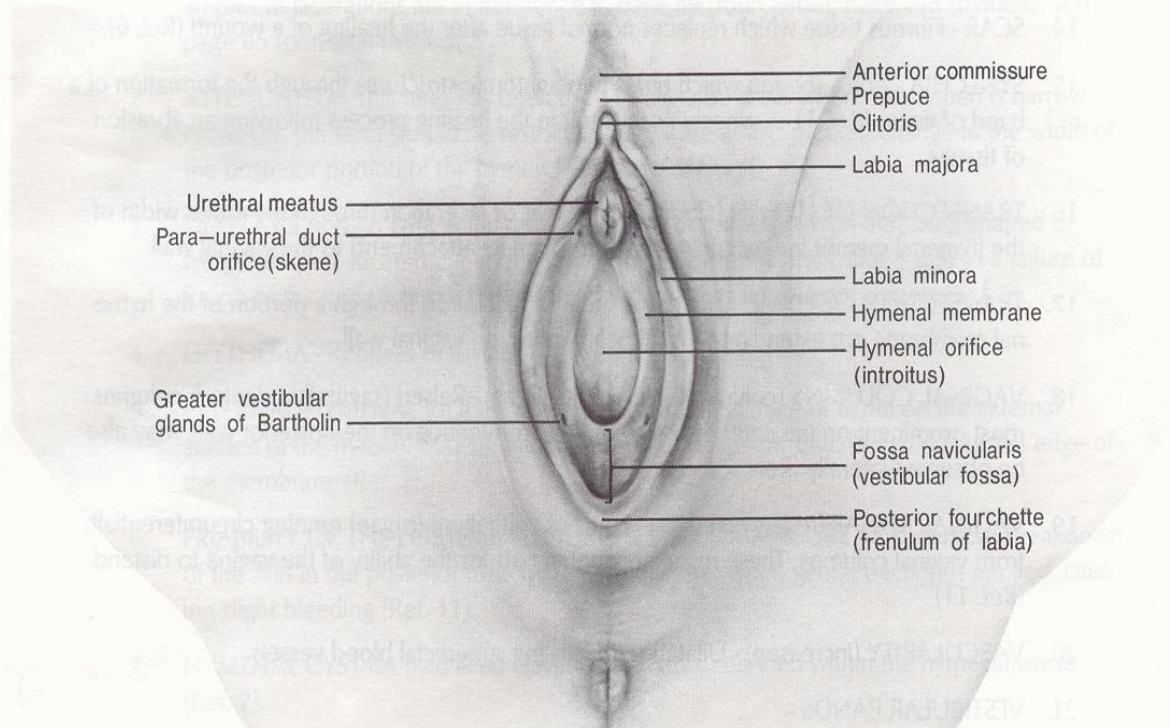
Building Rapport



Genital Anatomy

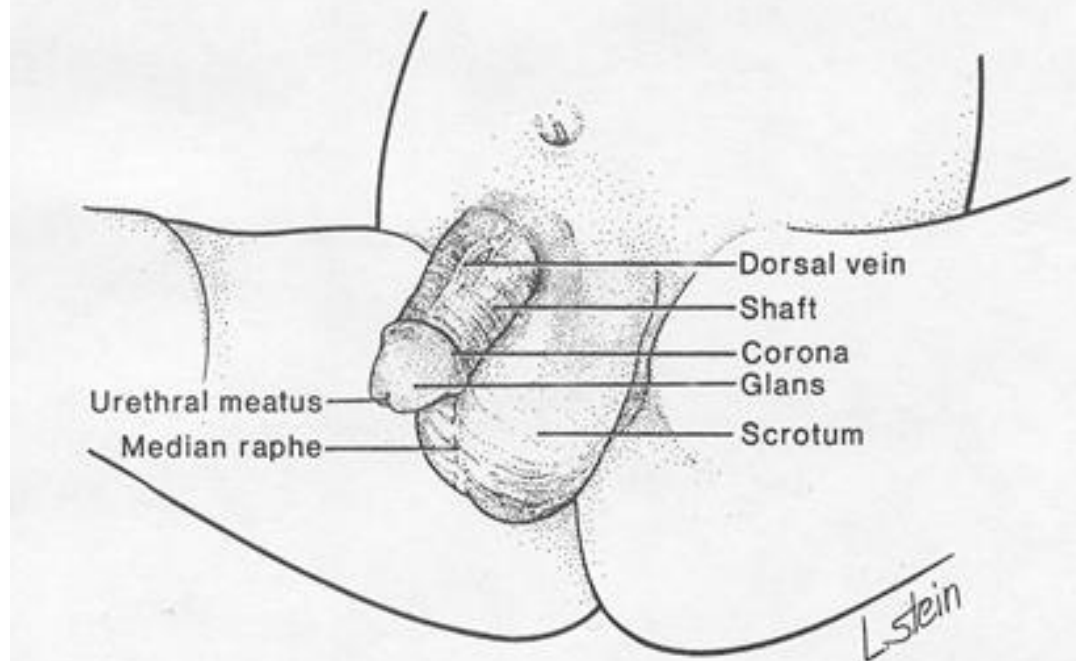
Description of Child's Genital Anatomy should be included in report

ANATOMIC STRUCTURES IN THE PREPUBERTAL GIRL



Reprinted with permission from Finkel M; DeJong AR: Medical findings in child sexual abuse. In Reece RM: Child Abuse, Medical Diagnosis and Management. Lea & Febiger, Philadelphia, 1994, p. 210.

PREPUBERTAL MALE GENITALIA (CIRCUMCISED)



Reprinted with permission from Giardino AP; Finkel M; Giardino ER; Seidl T; Ludwig S: A Practical Guide to the Evaluation of Sexual Abuse in the Prepubertal Child. Sage Publications, Newbury Park, CA, 1992, p. 33.

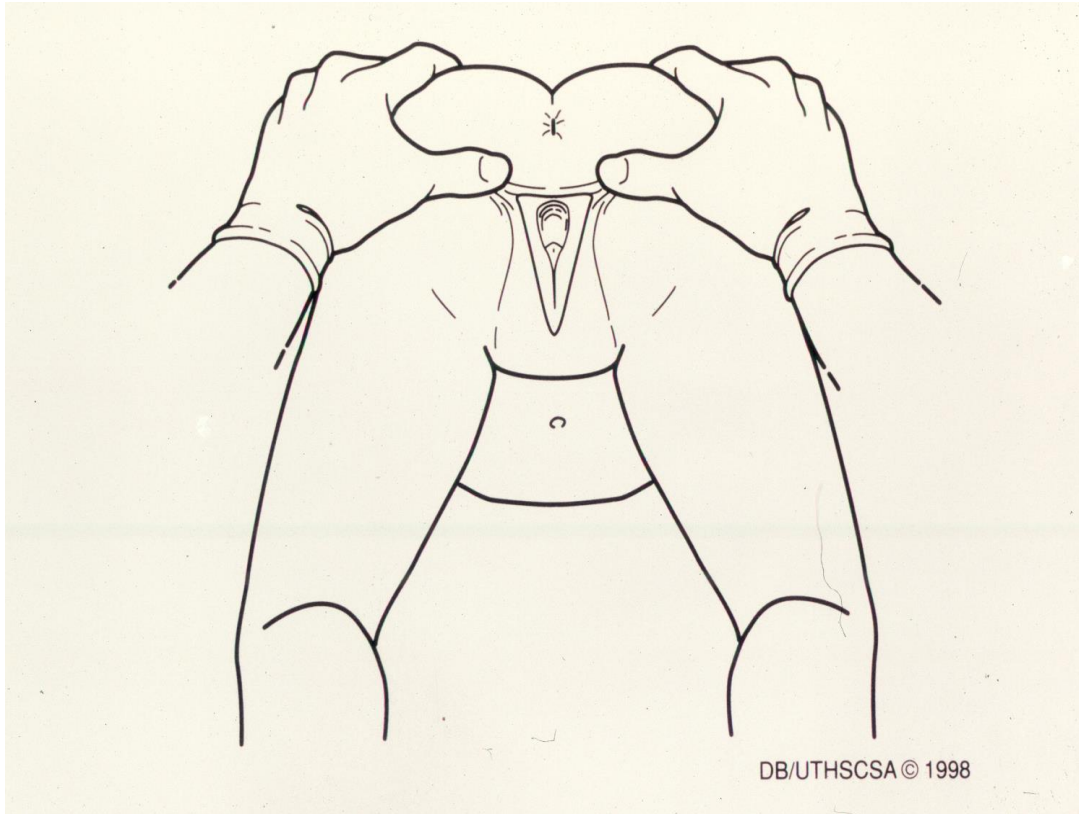
Supine Labial Traction



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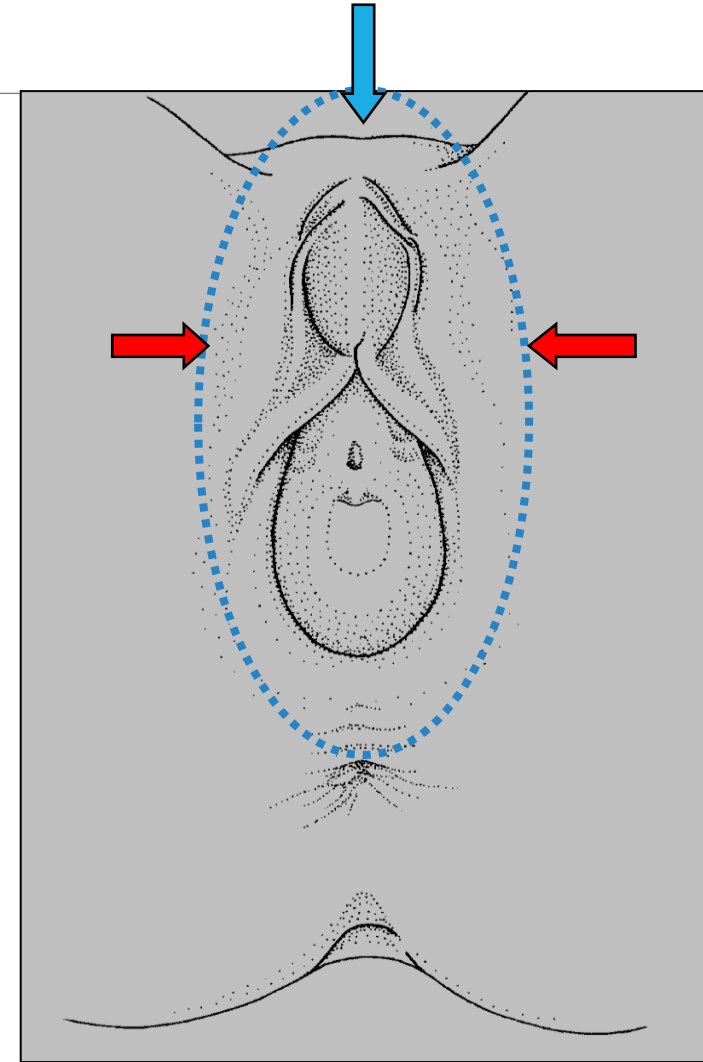
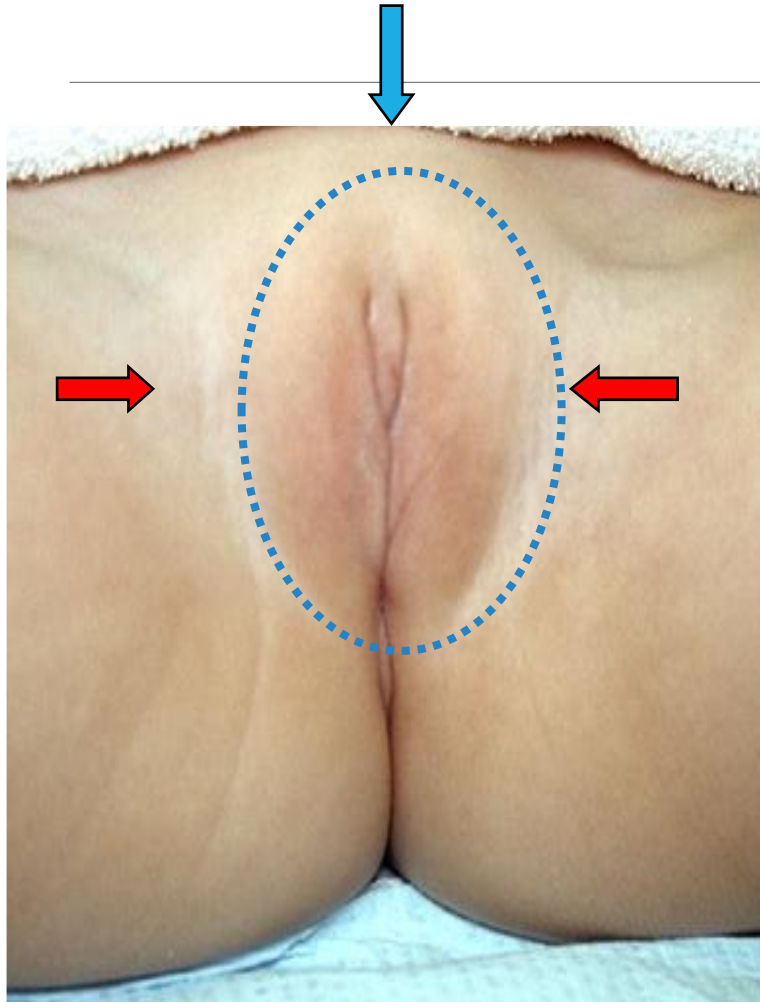
Prone Knee Chest Traction



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Vulva, Mons Pubis, Labia Majora



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Labia Minora



2 years



6 years



Tanner 4,5

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Normal Variants: Follicles and Linea vestibularis

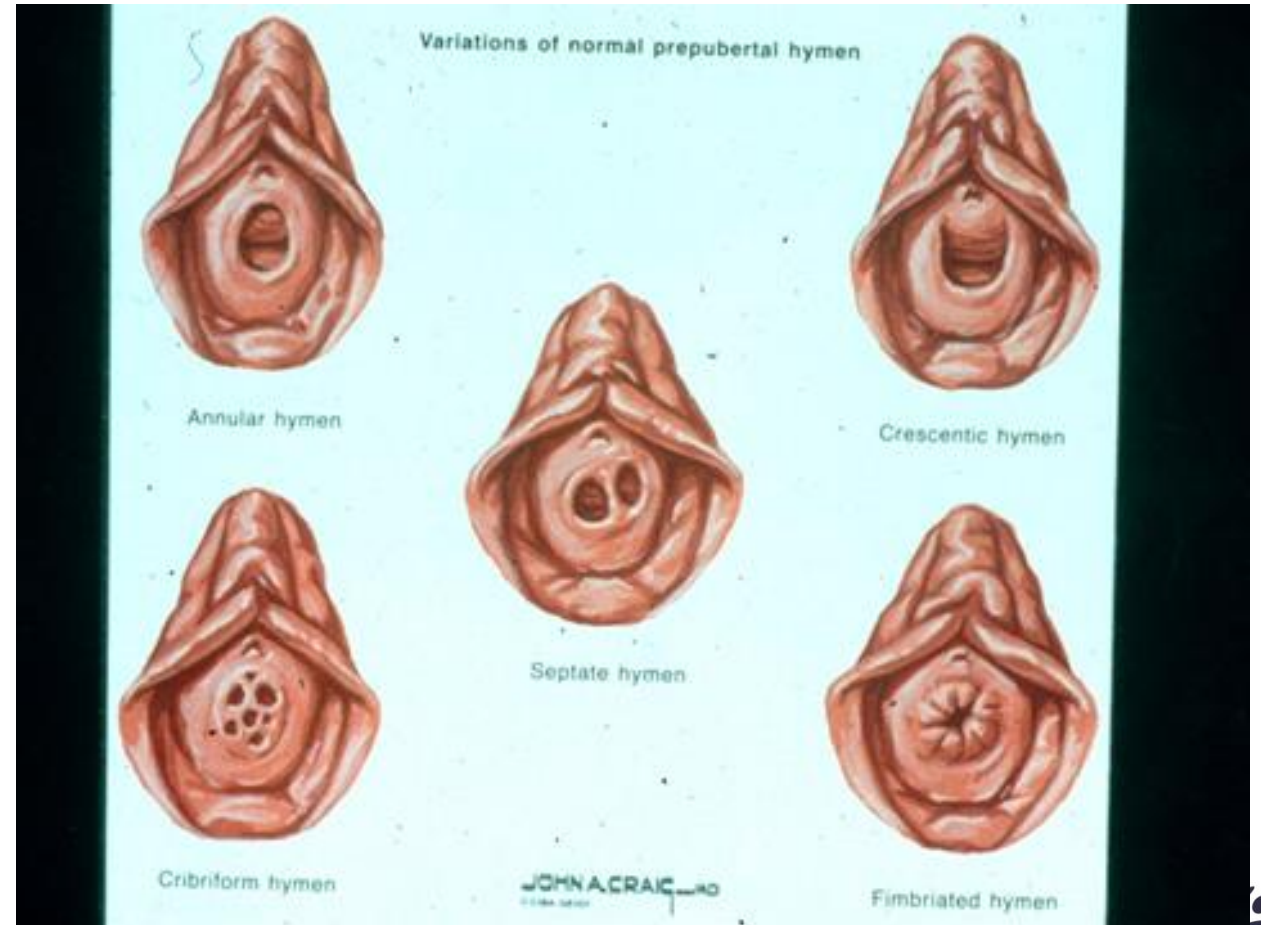


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The Hymen

- All females born with a hymen.
- There are variations in the structure and appearance over time.



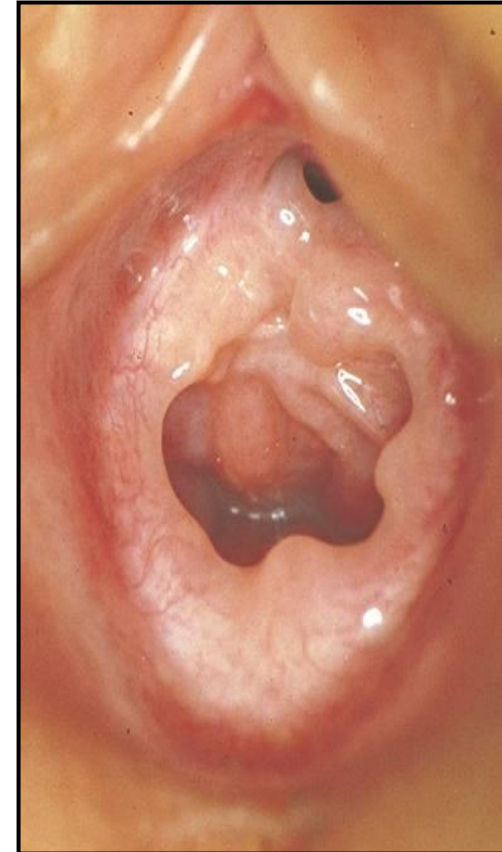
Hymen Types



crescentic



annular



fimbriated

More Hymen Types



sleeve-like 6 yr



septate



imperforate 9 yr

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Hymen Orifice Diameter

The hymenal orifice is the opening to the vagina through the hymenal membrane

- Horizontal/vertical diameter measurements of prepubertal children are available



Measurements vary with age, relaxation, exam technique

Hymen diameter: not a reliable indicator of abuse by itself

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McCann (1990), Berenson (1992)



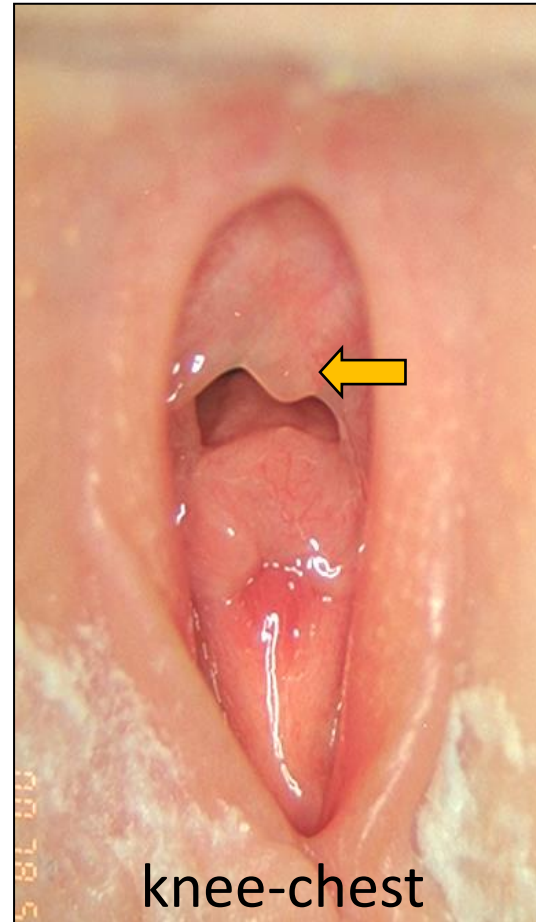
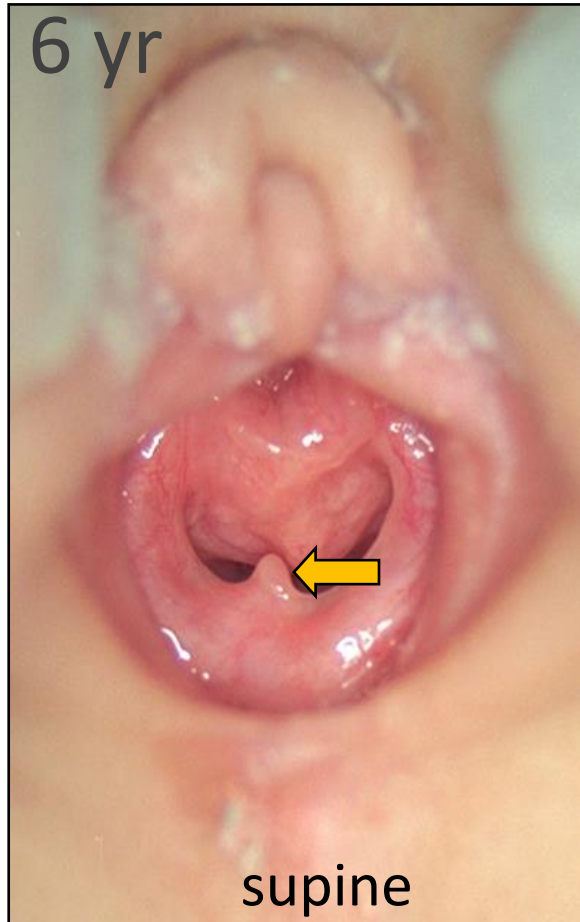
Hymen Edge, Contour, Symmetry

All are
affected by
the child's
position and
method of
examination

- Edge terms: smooth/thin, redundant/thick, rolled
- Contour terms: smooth, redundant, angular
- Symmetry
 - One-third in supine
 - One-half in knee chest



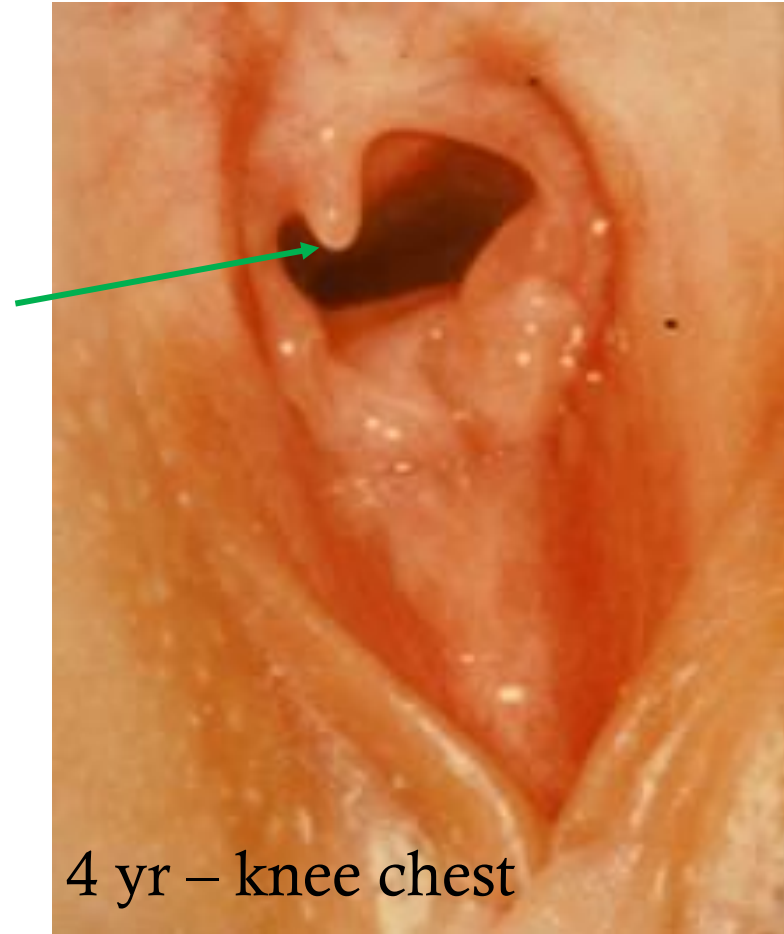
Hymen Mounds



- Solid, localized, rounded, thickened area of tissue on the edge of the hymen
- May be created by the hymenal attachment of a longitudinal intravaginal ridge

Hymenal Tag

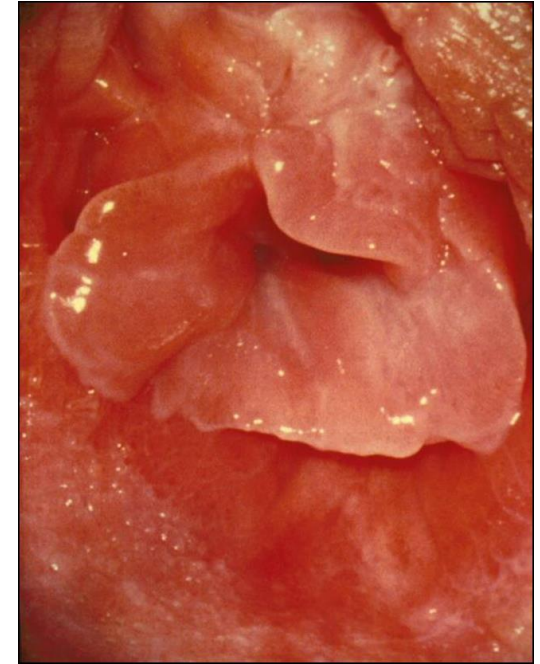
- Elongated projection of tissue arising from any location on hymen edge
- Commonly found in midline and may be an extension of a posterior vaginal ridge



4 yr – knee chest

Hymen Clefts/ Notches

- Shallow: less than half the hymen width
- Deep: greater than half the hymen width
- Transection: Complete to vaginal wall



Other Intravaginal Findings

Intravaginal
ridge



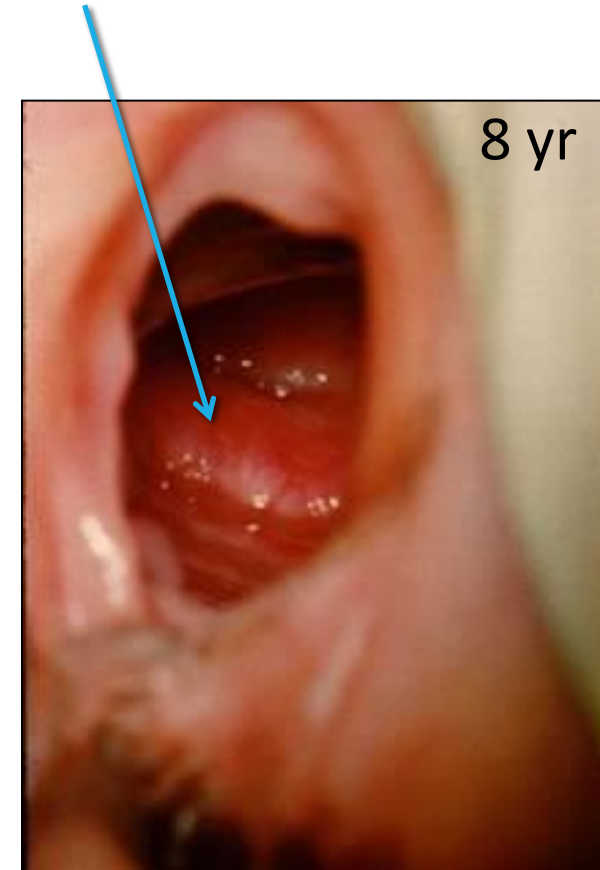
4 yr

Toilet paper
foreign body



3 yr

Intravaginal
septum



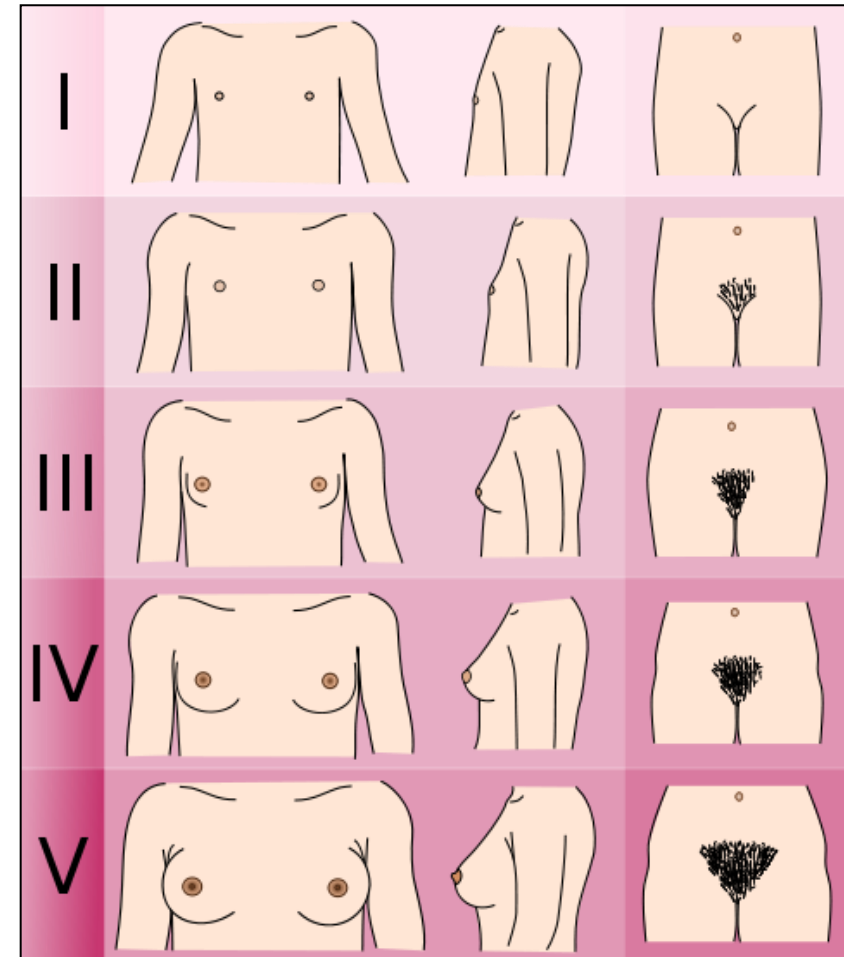
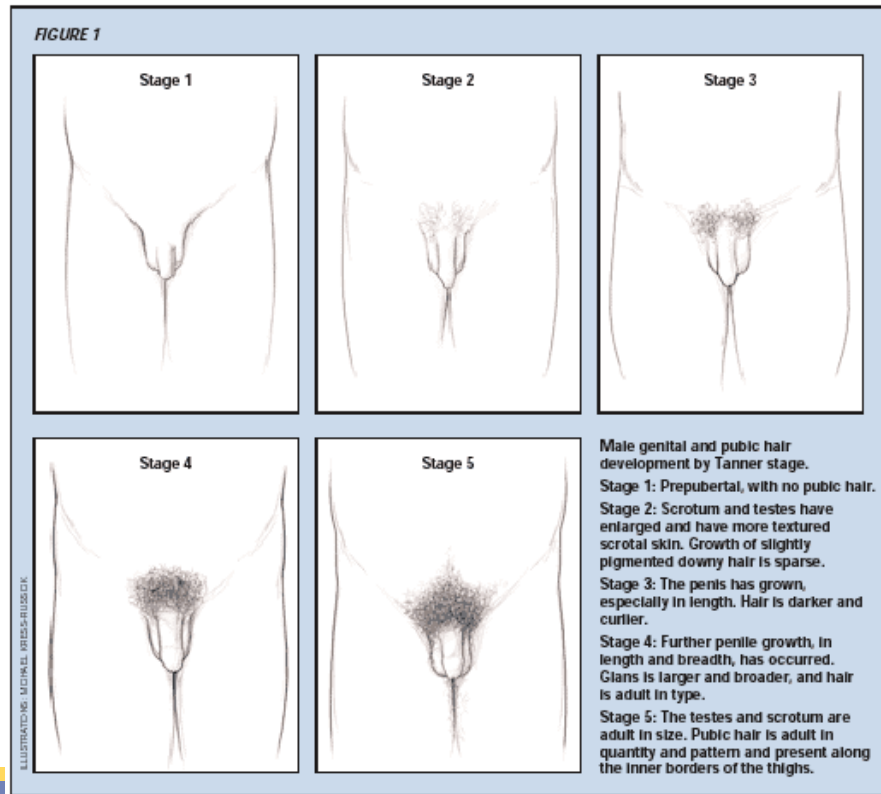
8 yr

Cervix

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Tanner Stages: sequence of changes involved in pubertal maturation



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Marshall and Tanner (1969)



Changes at Puberty

- Leukorrhea
- Intravaginal ridge hypertrophy
- Posterior column hypertrophy
- pH change – becomes more acidic
- Increased glycogen content
- Increase in bacterial content
- Lengthening of vaginal canal



Tanner I



Tanner II



Tanner III



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Tanner IV

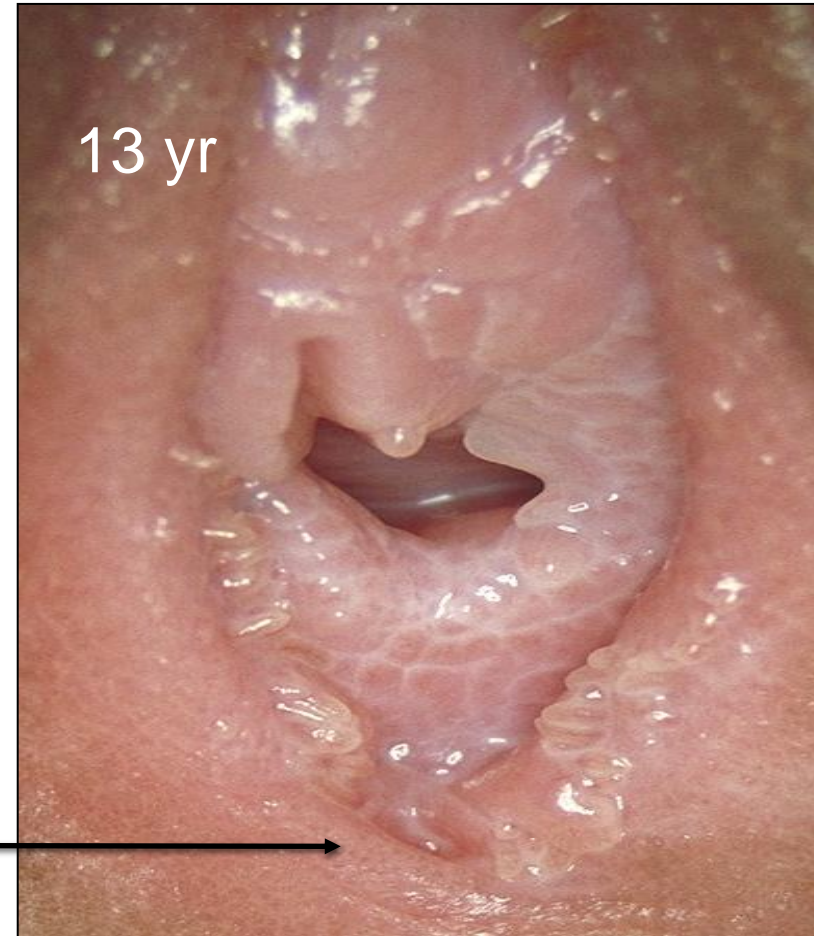


Tanner V

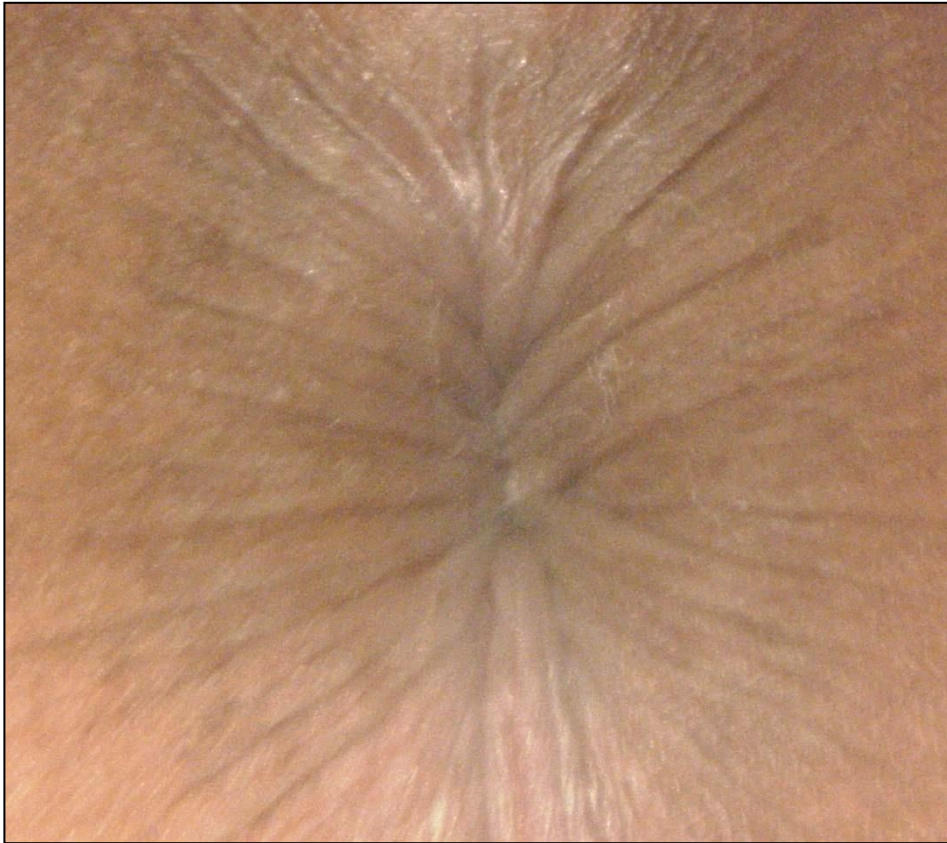


Fossa Navicularis Groove: A Normal Finding

- Frequently seen in Tanner 3 and above
- May be bordered by papillae
- May be straight or branched
- May be confused with trauma



Anus/Anal Orifice



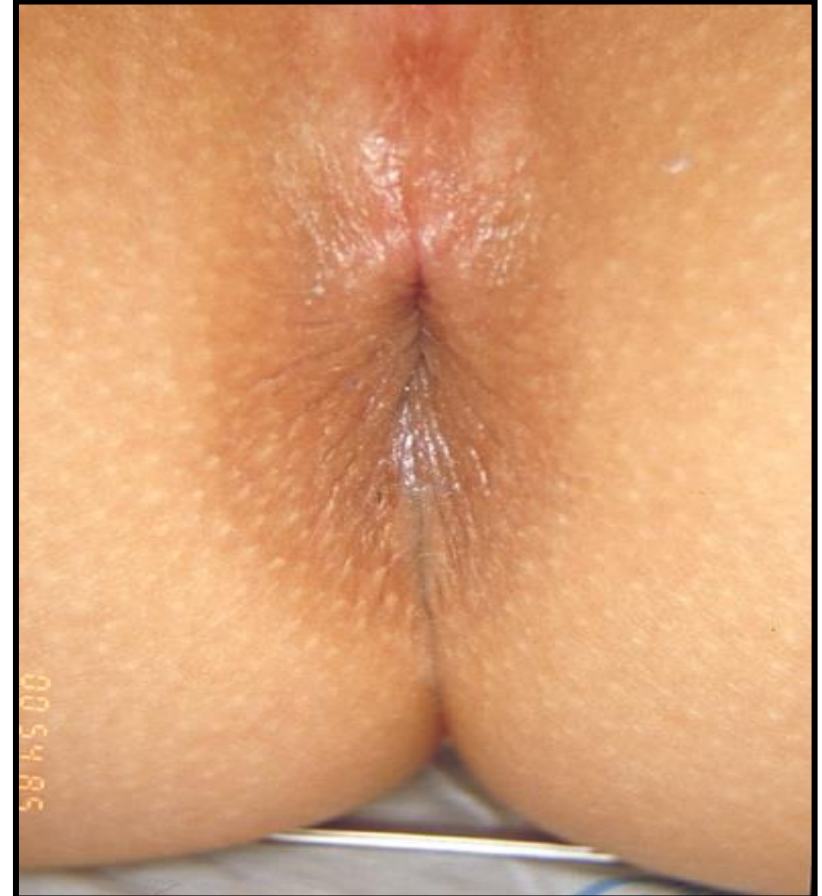
4 years



14 years



Perianal Pigmentation



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Anal Skin Tag



Prepuberty



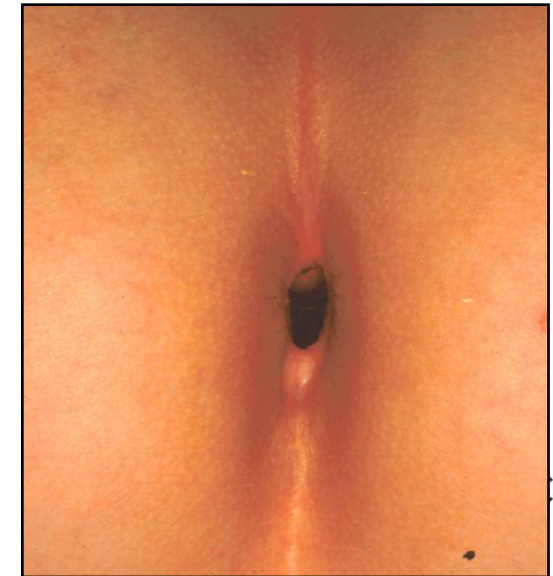
Prepuberty



Sensitive to estrogen at puberty

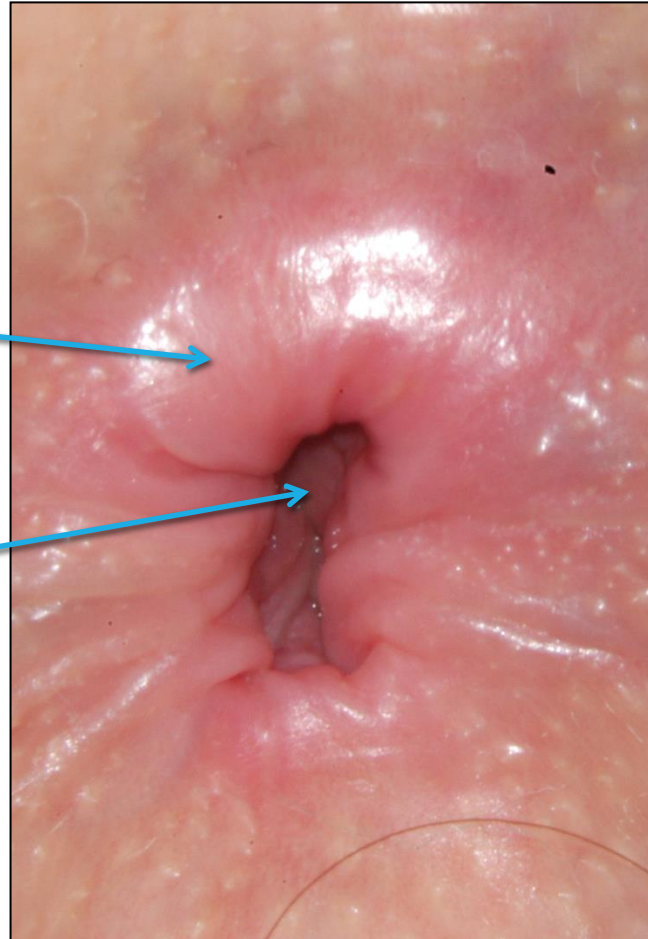
Diastasis ani

- Smooth area at the 6 or 12 o'clock positions in the perianal region
- Due to the absence of underlying corrugator external anal sphincter muscle
- Results in a loss of the usual anal skin folds in the area



Anal Sphincters

- External sphincter is open
- Internal anal sphincter not open



Anal Dilatation



Sexual Abuse Findings and Treatment - What does it mean?



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The Physical Exam: “It’s Normal to Be Normal”

Study* looked at 236 children, 8 months to 17 years.

Perpetrator conviction: 63% penile-genital contact.

Exam findings:

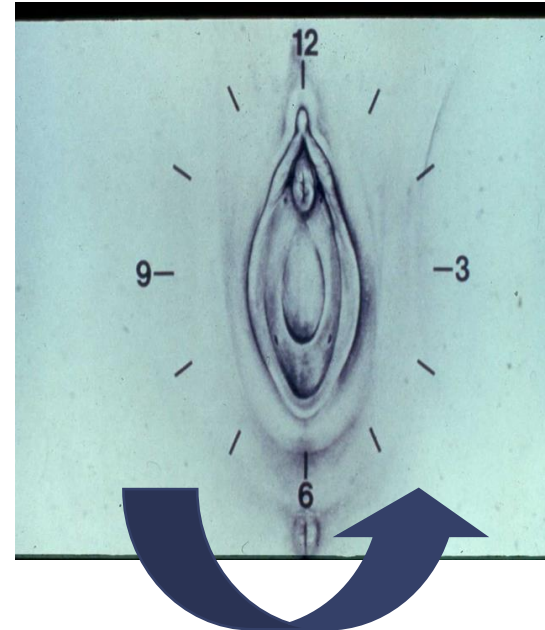
- 77% normal/nonspecific
- 14% abnormal, and
- 1% abnormal anal exam.
- <http://pediatrics.aappublications.org/content/94/3/310>

*Adams, J.A., Harper, K., Knudson, S. & Revilla, J. (1994). *Pediatrics*, 94 (3), 310-317.



Describing Injury to Female Anatomy

- Examination descriptions and findings are usually noted at a clock face location.
- “Acute bruise and transection are seen at 5 o’clock.”
- “Tear of anus at 6 o’clock.”



Most abuse trauma is seen in posterior locations between 3 and 9 o'clock.

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Results of the Physical Exam

Interpretation:

- Normal,
- Normal Variant,
- Findings caused by trauma,
- Indeterminate,
- Need more information or consistent with medical information



Questions?



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