Pergamon

Child Abuse & Neglect 30 (2006) 367–380

Child Abuse & Neglect

Urgent medical assessment after child sexual abuse

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Received 16 April 2004; received in revised form 31 October 2005; accepted 6 November 2005

Abstract

Background: Immediate medical assessment has been recommended for children after sexual abuse to identify physical injuries, secure forensic evidence, and provide for the safety of the child. However, it is unclear whether young children seen urgently within 72 hours of reported sexual contact would have higher frequencies of interview or examination findings as compared to those seen non-urgently or whether forensic findings would be affected by child characteristics, type of reported contact, or later events.
Design/setting: We evaluated 190 consecutive cases of children under 13 years of age urgently referred during a 5-year period in 1998–2003 to a community child advocacy center and compared them to those non-urgently referred with regard to their physical examination findings, any sexually transmitted infections or forensic evidence, gender, pubertal development, type of contact, reported ejaculation, later bathing or changing clothes, time to examination, and gender, age and relationship of alleged perpetrator.
Results: Children seen urgently were younger and had less frequent CPS involvement, more disclosures, and more positive physical examinations, and had more contact with older perpetrators than those seen non-urgently. Overall, most children were female and had normal or non-specific physical examinations. Certain case characteristics were predictive of evidence isolation in the 9% who had positive forensic evidence identified. Semen or sperm was identified from body swabs only from non-bathed, female children older than 10 years of age or on clothing or objects.
Conclusions: Female children over 10 years old who report ejaculation or genital contact without bathing have the highest likelihood of positive examinations or forensic evidence. While there are other potential benefits of

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0145-2134/$ – see front matter
doi:10.1016/j.chiabu.2005.11.002

early examination, physicians seeking to identify forensic evidence should consider the needs of the child and other factors when determining the timing of medical assessment after sexual abuse.

Keywords: Child sexual abuse; Sexual assault; Urgent referral; Forensic evidence

Introduction

The medical diagnosis of child sexual abuse (CSA) rests primarily on the history and may be supported by physical evidence such as positive physical examination findings, detection of sexually transmitted infections (STI) or isolation of forensic trace evidence (Committee on Child Abuse and Neglect, 1991, 1999). Children who have been sexually abused have been noted to have specific patterns of disclosure, physical examination and forensic findings which may assist in the identification and prosecution of alleged perpetrators and assure protection from further abuse (Adams, Harper, & Knudson, 1992; Berenson et al., 2000; Berenson, Heger, Hayes, Bailey, & Emans, 1992; Heger, Ticson, Velasquez, & Bernier, 2002; McCann, Voris, & Simon 1992; Palusci et al., 1999).

While the history obtained from the child is paramount, the diagnosis of CSA is augmented by physical findings or other forensic evidence in a small but important number of cases and is affected by the child's age, gender and stage of sexual development (Adams, 1997; Christian et al., 2000; Enos, Conrath, & Byer, 1986; Heger et al., 2002). Differences in examination findings among children, adolescents and adults have been noted after sexual assault, and guidelines for the timing of examination are based primarily on evidence regarding the isolation of spermatozoa from adult female genital tracts (Jones, Rossman, Wynn, Dunnuck, & Schwartz, 2003; Silverman & Silverman, 1978; Soules, Pollard, Brown, & Verma, 1978). Older children, females, those with genital-genital contact with older males, and those seen within shorter periods of time are believed to have a greater likelihood of disclosure, positive physical examination findings or identifiable trace evidence (Christian et al., 2000; Enos et al., 1986; Heger et al., 2002). In a retrospective review of forensic tests of 273 children less than 10 years of age, Christian noted that 25% had positive forensic evidence obtained during emergency department visits, 64% of which was on clothing or bedding, and only one child in this Philadelphia case series had body evidence (a pubic hair) when seen after 24 hours or more after an assault (Christian et al., 2000).

Recent or acute sexual contact is generally defined to have occurred when children are brought for medical evaluation within 72 hours of contact (Committee on Child Abuse and Neglect, 1999). While the American Academy of Pediatrics has recommended immediate medical examination for children after recent sexual contact, the immediate need for such evaluation may preclude the use of child-friendly settings such as the child's medical home or specialized programs, such as child advocacy centers or sexual assault clinics, which may use techniques such as videocolposcopy to reduce further trauma to the child (Palusci & Cyrus, 2001). It is unclear whether young or prepubertal children seen within 72 hours of sexual contact have rates of disclosure, positive physical findings, sexually transmitted infections or forensic evidence differing from those seen non-urgently. There may be certain subgroups of children who benefit more from immediate medical evaluation, and, conversely, there may be others for whom the evaluation could be modified or delayed to minimize further trauma while preserving important physical evidence and maximizing the potential therapeutic effect of the physical examination (Palusci et al., 1999).