Abstract:
The medical assessment of children and adolescents for suspected sexual abuse or assault includes gathering a history from the child, examination and photodocumentation of bodily and anogenital findings, forensic evidence collection, and testing for sexually transmitted infections, when indicated. Most children will not have signs of injury or infection, and the child and family need to be reassured that an absence of injury does not mean that the abuse did not happen. This article provides an overview of current recommendations concerning the medical assessment, including recent updates in the interpretation of examination findings, sexually transmitted infection testing methods, follow-up examinations or testing, and practice recommendations for quality improvement. Changes in the approach to interpretation of anogenital findings table are also reviewed.

Note: The material in this manuscript has been adapted from: Adams JA, Kellogg ND, Farst KJ et al. Updated guidelines for the medical assessment and care of children who may have been sexually abused. *J Pediatr Adolesc Gynecol* (2015), doi: 10.1016/j/jpag.2015.01.007; available at: http://dx.doi.org/10.1016/j.jpag.2015.01.007, which is made available through a Creative Commons license.

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*California Clinical Forensic Medical Training Center, Sacramento, CA; †University of Texas–San Antonio Health Sciences, San

Medical Care for Children Who May Have Been Sexually Abused: An Update for 2016

Joyce A. Adams, MD*, Nancy D. Kellogg, MD†, Rebecca Moles, MD‡

A small group of experts in child abuse pediatrics reviewed the literature in the field of medical evaluation of suspected sexual abuse that was published between 2007 and 2015, to determine if guidelines for medical care, published in 2007,[1] should be updated. The group reached consensus on which changes should be made, and the updated guidelines were published online in the *Journal of Pediatric and Adolescent Gynecology* in 2015 and in print in 2016.[2] A summary of the changes and recommendations is presented here.

MEDICAL HISTORY

A detailed and complete history is usually the most essential component of the medical assessment for suspected sexual abuse. Although some information can be obtained from the parent, children should also be interviewed separately when possible, minimizing concerns for the influence of parental reactions. Children should be encouraged to provide a narrative of events, beginning with questions such as:"Can you tell me why you came in today?",[3] followed by intermittent clarifying questions ("when you say 'private'

Antonio, TX; ‡Connecticut Children's Medical Center, Hartford, CT.

Reprint requests and correspondence: Joyce A. Adams, MD, 401 Florin Rd, Apt 115, Sacramento, CA 95831.
jadams@ucsd.edu

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which body part do you mean?") as needed. Verbatim documentation of questions and responses is recommended when possible.[4] Because protocols vary from community to community, it is important to coordinate information gathering with other professionals such as investigators and forensic interviewers.

Physical symptoms during or after abusive events, such as dysuria,[5] genital area pain, bleeding, and discharge, should be documented. In addition, children and adolescents should be screened for trauma symptoms, self-blame,[6] and perceived parental belief and support. Although most, if not all, child and adolescent victims of sexual assault benefit from mental health support and treatment, a child who expresses self-injurious thoughts or behaviors may require a more immediate mental health assessment.

EXAMINATION FINDINGS

All children who are suspected victims of sexual abuse should be offered an examination performed by a medical provider with specialized training in sexual abuse evaluation (Table 1). The medical evaluation may need to be done on an emergency basis, or be considered urgent or nonurgent (Table 2). Follow-up examinations may be helpful to reassess findings and conduct further sexually transmitted infection (STI) testing.[7]

Children and adolescents presenting for sexual abuse or assault evaluations should be carefully examined for both bodily and anogenital injuries. Photodocumentation is recommended as a standard of care[8] especially for examinations with positive findings because abnormal anogenital examination findings are rare. Diagnostic quality images or videos allow for expert review, teaching, and legal proceedings;[9] however, photographs never substitute for detailed written descriptions of the examination findings. Acute anogenital findings are more common than healed trauma, but most examination findings are normal.[10,11] Examination findings and current recommendations for interpretations are listed in Table 3. Clinicians should ensure that children, adolescents, and their family members understand that a normal examination finding does not exclude abuse or any type of sexual act.

The interpretation of anogenital findings is summarized in Table 3, including a section on conditions that often are erroneously attributed to sexual abuse trauma.[12] This table has been updated consistently since 1992.[13] The most significant recent changes include the following: (1) changing the name of the group of findings for which there is no expert consensus regarding significance with respect to abuse from "indeterminate" to "no expert consensus," (2) removal of flattened anal folds and references to anal dilatation measurements because this is a dynamic sign and difficult to measure, and (3) placement of a deep hymen notch (extending nearly to the base of the hymen) in the "no consensus" category.

Findings are listed in the "no consensus" section when there is insufficient or conflicting evidence from research studies that the findings, in isolation, are clearly associated with sexual abuse. In the footnotes of Table 3 for this section, it is explained that if a child gives a clear disclosure of sexual abuse, and the findings are confirmed by further testing or expert review, they can be considered to support the child's disclosure of the abuse. Other recent changes and additions are noted in bold type in Table 3.

Figure 1 is a photograph of the genital area of a 7-year-old girl, with labels indicating the details of genital anatomy. In Figure 2, the labeled photograph of the genital area of a young adolescent girl shows the appearance of a hymen transection, a nonacute finding. Figure 3 shows the anal area of a child and a finding that can be mistaken for signs of trauma. The external anal sphincter is partially relaxed, so that part of the pectinate line is revealed (Figure 4).

FORENSIC EVIDENCE COLLECTION

Research studies have confirmed that DNA is predominantly recovered when examinations of prepubertal children are conducted less than 24 hours from the time of the assault.[14,15] Importantly, the presence of significant physical findings does not predict recovery of foreign DNA and should not be the basis for collecting forensic evidence.[16]

At this time, forensic evidence collection is recommended for sexual contact that may have resulted in the exchange of biologic material within 24 hours in prepubertal children and within 72 hours in adolescents.[17] Some young children will still benefit from evidence collection beyond 24 hours,[18] especially in areas where DNA