"Haven't I Seen You Before?" The Dilemma of Repeated Examinations for Suspected Child Sexual Abuse

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Disclosure

I have nothing to disclose.

Objectives

- Recognize patterns of recurrent allegations of child sexual abuse
- Describe how documentation can assist interpretation of the findings
- Analyze management options for recurrent child abuse cases

Your First Patient Is Here

A 6 year-old girl presents to the clinic because she has reported to her mother that dad put his penis inside of her and that he cut her because she previously disclosed abuse.

Mom had contacted the clinic yesterday, with concerns that the private area looked red with a greenish discharge. Since making the phone call yesterday, she went to the Emergency Department, the CAC in her home county and now our clinic.

An evidence collection kit was obtained in the ED. Her examination shows a normal crescent hymen with a whitened area in the fossa.

The doctor recognizes the patient from the previous year and decides that she must compare the photos of the genitalia.

Child Protective Services has been involved on and off for three years and call the clinic to ask about the doctor's opinion.

July 2013

- Seen for rash, no GU symptoms, had been bedwetting, masturbating, sexual comments and disclosure to babysitter about dad and grandfather.

April 2014

- Allegation that dad put screwdriver in her buttocks

December 2014

- Screwdriver and hammer in butt
- Changed pediatricians

Medical Examinations

- Digital photo from CARE exam July 2013: Normal crescent hymen. Whitish area in fossa navicularis, small adhesion in posterior fourchette. She also had photos of a pinpoint rash.
- DVD from SANE exam April 2014: Normal GU exam, small adhesion in posterior fourchette.
- Digital photo from CARE exam 2 weeks later in April: Normal crescent hymen. Whitish area in fossa navicularis, small adhesion in posterior fourchette. Slightly increased whitish area, but basically unchanged from previously. Better photo (better view of the whitish area) than previously.
- Digital photo from CARE exam in April 2014: Normal crescent hymen. Whitish area in fossa navicularis, small adhesion in posterior fourchette.
- Digital photo from CARE exam in December 2014: Exam unchanged. Photo of hand lesion.
- DVD from SANE exam on April 2015: Normal GU exam, similar adhesion.
- Digital photo from CARE exam April 2015: Exam unchanged.

Signs of Concern

- Repeated examinations and interviews
- Inconsistencies in the histories
- Patient affect
- Other professionals' concerns
- Lack of supporting physical findings
- Lack of supporting investigative evidence
- Family strife

Problem Definition

Situation

A six year-old girl has been brought to medical attention multiple times for suspicion of sexual abuse.

Complication

Patient has become "conditioned" to the repeated allegations, interviews and examinations.

Stakeholders

Mom	CPS
Dad	Police
Grandma	Medical
	Therapists

Scope

Three years of concerns, seven examinations, numerous interviews.

Problem Statement

Repeated examinations with no suspicious findings.

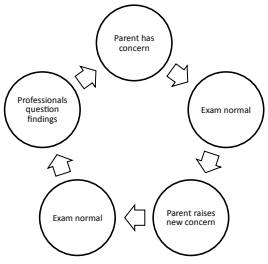
Hypotheses

Child sexual abuse vs. "False" allegations

Possible Reasons for Repeat Exams

- Medical issue
- Recurrent sexual abuse
- Induction of symptoms/signs of abuse
- Fabrication of abuse
- Parental mental illness

When the Cycle Starts



Steps to Break the Cycle

- If possible, discuss concerns with parent
- Review all records and photos
- Create a timeline of events
- Meet with professionals to discuss
- Mental health evaluation of parent
- Advise controlled exams
- Summarize findings for legal proceedings

Controlled Examinations

- Advise Monday morning examinations (not ED)
- Advise all exams by same provider
- Reduce number of evidence kits
- Reduce number of tests for STIs
- Take photos of all exams

What We Did

- Controlled exams
- Timeline of events (8 pages)
- Review of all records
- Summarize in letter (6 pages)

Your Second Patient Is Here

An 11 year- old girl presents to the clinic because she has had burning and itching of her genital area for 5 weeks.

Mom is very concerned and feels that the patient cannot go to school because she is in so much discomfort. The patient sits in the house all day wearing just a T-shirt and no underwear because she is so uncomfortable. She sits in a tub for up to 3 hours per day. She does not wake up at night with itching. There is no disclosure of sexual abuse and she is an only child. Mom and dad are married and live together.

The patient has been seen twice by her primary care provider, twice by a women's health practitioner and treatments have included diflucan, treatment for pinworm, and creams that included miconozole and triamcinolone.

The patient denies use of bubble baths, new shampoos, or change in detergents. No prior history of pruritus. No dysuria. No hematuria.

No agencies are involved.

Pre-pubertal Child with Recurrent Vaginal Pruritus

Recurrent Vaginal Pruritus---Pediatric Annals

A Prepubertal Girl with Persistent Vaginal Pruritus; Tanuja M. Rajpal, MD; Nima Mottaghi, MD; Louis Keith, MD, PhD; Ashlesha Patel, MD, MPH; July 2014 – Volume 43 ; Issue 7: 262-264.

http://www.healio.com/pediatrics/journals/pedann/2014-7-43-7/%7Bf955fc5f-37f2-4520-906a-bb7f5e0cc2f6%7D/a-prepubertal-girl-with-persistent-vaginal-pruritus

Recurrent Vaginal Pruritus— BMJ

Microbiological findings of vulvovaginitis in prepubertal girls. Žana Bumbulienė, 1 Karolina Venclavičiūtė, 2 Diana Ramašauskaitė, 1 Audronė Arlauskienė, 1 Elžbieta Bumbul,3 Gražina Drąsutienė 1 Postgrad Med J 2014;90:8–12.

http://pmj.bmj.com/content/90/1059/8.full.pdf+html

Recurrent Vaginal Pruritus- Medscape

Vaginitis (inflammation of the vagina) is the most common gynecologic condition encountered in the office

http://emedicine.medscape.com/article/257141-overview

Pinworm

- *E. vermicularis* should always be considered as a specific cause of recurrent "nonspecific" vaginitis.
- The fecal-oral route is the only means of transmission, and humans are the only natural host. The embryonated eggs are ingested and hatch in the upper part of the small intestine, where they develop into adults and reside in the large intestine.
- Female worms cause considerable itching after migration to the perineum and anus, where they lay their eggs and die. The ova remain infective for up to 20 days. Occasionally, they enter the vagina and urethra, and they may also invade the abdominal cavity via the cervix and the uterus.
- Pruritus ani is the most common symptom of enterobiasis, occurring primarily in the evenings due to the nocturnal migration of gravid females to lay their eggs.

Vulvovaginitis Symptoms

- General redness
- Vaginal Discharge
- Itch
- Soreness
- Bloody discharge
- Rash
- Polyuria
- Dysuria

Bumbulienė, etal. Microbiological findings of vulvovaginitis in prepubertal girls. *Postgrad Med J* 2014;90:8–12.

Vulvovaginitis Causes

- Positive micro bio findings in all 115 symptomatic girls and 60% of the control group (!)
- Note Candida is rare (not enough estrogen to sustain growth of yeast)
- No shigella on this list
- Group A strep most common pathogen
- E coli is the most common conditional pathogen
- Pathogenic flora was found exclusively in girls with vulvovaginitis.

Study Group: 115 prepubertal girls with vulvovaginitis symptoms and additionally 20 age-matched asymptomatic girls.

Bumbulienė, etal. Microbiological findings of vulvovaginitis in prepubertal girls. *Postgrad Med J* 2014;90:8–12.

Anatomic Reasons for Vaginitis

- Vaginal pH is neutral or alkaline, with an absence of lactobacillus, lactic acid and leucocytes
- Physiologic atrophy of vaginal epithelium (columnar)
- Absent vaginal mucous glands –minimal vaginal secretions
- Lack of protective labial fat pads
- Gram-positive cocci and anaerobic gram-negatives
- Proximity of the vulva to the anal orifice
- Labia is thin with a thin hymen

Behavioral Risk Factors

- Poor hygiene
- Inadequate front-to-back wiping movements after evacuation
- Exploration of their own bodies (insertion of foreign bodies)
- Use of local irritants (bubble baths, shampoos)
- Swimming and leaving the suit on

Predisposing Factors

- Obesity
- Diabetes, HIV (candida)
- Recent use of antibiotics
- Co-exist with UTI
- Digital transmission of viruses and Group A strep
- Risk of pinworms
- Congenital GU abnormality (ectopic ureter, rectovaginal fistulas)
- Lichen Sclerosis or other dermatologic condition

Other Issues

- Hymenal septum

Facts

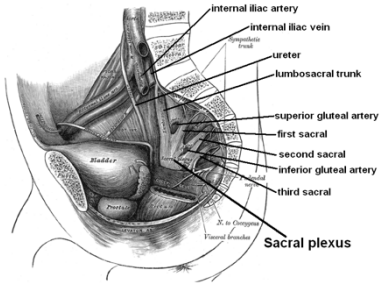
- No excoriations; no itching at night or during history or exam
- Large labia minora (dry)
- No disclosures of abuse, no bullying at school
- History of chronic abdominal pain
- Already treated for most common pathogens
- School attendance (not attending)

One week later, still no relief.

More History

- No relief with creams
- Talked to mom alone; no concerns of abuse
- Talked to patient alone; no disclosure
- Complains of poor appetite & abdominal pain
- No weight loss
- Mom tearful
- History of back injury one week before symptoms
- Patient had appointment with PMD and women's health (two days in a row)

What about sacral nerves?



https://en.wikipedia.org/wiki/Sacral_plexus#/media/File:Relations_of_the_sacral_plexus.png

Differential Diagnosis

- Conversion reaction
- Sacral nerve injury (no bladder or bowel incontinence)
- ?

Summary

- Recurrent presentations to health care providers of pre-pubertal girls who have vaginal complaints can be challenging.
- Consider:
  - Vaginitis or other medical cause
  - Recurrent sexual abuse
  - False allegations
  - Conversion reactions
- The diagnosis is most commonly vaginitis due to pinworms, strep or poor hygiene.
- UTI can present as a vaginitis.

Additional References

- van Eyk N, Allen L, Giesbrecht E, et al. Pediatric vulvovaginal disorders: a diagnostic approach and review of the literature. *J Obstet Gynaecol Can*. 2009;31(9): 850–862.
- Roesler TA, Jenny C. *Medical Child Abuse: Beyond Munchausen Syndrome by Proxy.* American Academy of Pediatrics; 2009.