Pediatric sexual abuse/assault literature update - 2013

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The Plan

• Will briefly highlight article
• Please contribute any interesting points
• As a small group answer the attached questions
Diagnostic accuracy in child sexual abuse medical evaluation: Role of experience, training, and expert case review

Joyce A. Adams a,*, Suzanne P. Starling b, Lori D. Frasier c, Vincent J. Palusci d, Robert Allan Shapiro e, Martin A. Finkel f, Ann S. Botash g
Conclusions
Conclusions

- Training, discipline and clinical experience were significantly associated with the ability to correctly identify medical findings and apply medical knowledge to correctly interpret findings in our survey of participants who perform evaluations for suspected CSA.

- 5 exams or more per month may be required for ongoing competency in interpreting medical and lab findings in children.

- Those not meeting this criteria should be reviewed by a more experienced specialists to improve accuracy.
Questions

• If you are not completing 5 exams per month how are you ensuring accuracy with your exam findings?

• How can you better obtain/participate in continuing education activities?
Value of Follow-up Examinations of Children and Adolescents Evaluated for Sexual Abuse and Assault
Amy R. Gavril, Nancy D. Kellogg and Prakash Nair
*Pediatrics* 2012;129;282; originally published online January 30, 2012;
DOI: 10.1542/peds.2011-0804
<table>
<thead>
<tr>
<th>Examination 1 Results</th>
<th>Decreased Likelihood of Trauma (n = 82)</th>
<th>Increased Likelihood of Trauma (n = 47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal/nonspecific (n = 435)</td>
<td>8&lt;sup&gt;a&lt;/sup&gt;</td>
<td>16</td>
</tr>
<tr>
<td>Indeterminate (n = 31)</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Positive, healed (n = 38)</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Positive, acute (n = 143)</td>
<td>8</td>
<td>1&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Unknown (n = 80)</td>
<td>45</td>
<td>24</td>
</tr>
</tbody>
</table>

<sup>a</sup> Seven were nonspecific findings that could be attributed to trauma (eg, focal erythema) found to be a nontraumatic congenital variant at follow-up (eg, hemangioma, nevus); 1 patient had ulcers and vesicles initially attributed to sexually transmitted herpes simplex virus, but follow-up cultures confirmed group A streptococcal infection.

<sup>b</sup> One patient (who denied interim sexual contact) had a single finding of acute trauma on the initial examination and multiple significant findings of acute trauma on follow-up examination.
Conclusions

• “Follow-up exam of suspected child victims of sexual abuse changed the interpretation of trauma likelihood in 17.7% of patients and identified STIs in 6.5% patients affecting 23.2% of study population”

• “Less examiner experience for exam 1 was associated with a change in trauma assessment on exam 2”
• “follow-up examinations for pediatric patients undergoing sexual abuse assessments influenced when diagnosis of trauma and detection of STIs at a rate comparable to the detection of additional fractures on f/u skeletal survey in a suspected victim of physical abuse “
Case

- 13 yr old girl
- Sexually assaulted 48 hours ago
- Seen in ER by SANE nurse & ER Physician
- Examination findings – difficult to visualize hymenal opening
- Did not want any meds – refused HIV PEP, STI Prophylaxis – did take ECP
- Did have forensic evidence collected
- Did not want mom to know she was in ER for sexual assault – had to call friend’s parent to pick her up
Questions

• Should this adolescent come back in for follow-up?
• When should this occur? Who should do the exam?
• What would you want to do during follow-up?
• Overall how can you better ensure follow-up with the acute sexual abuse patients in your community?
Viewpoint

Sexual assault in prepubertal girls: ‘It is normal to be normal’ – or is it? Evidence of vaginal penetration in prepubertal girls

Theodore N Hariton MD FACOG
Consultant, California Forensic Medical Training Center, Sacramento, CA, USA
Correspondence: 65344 East Rocky Mesa Drive, Tucson, AZ 85739, USA. Email: Tnh1@earthlink.net
• Dr Hariton (author of this article) is testifying as an expert for the defence on your case

• The crown has asked you to respond to his statements ....
• “acute sexual trauma will be obvious during an examination if penile vaginal penetration has occurred”

• Do you agree or disagree and why?
• “When comparing the diameter of the average adult male penis of 35-39mm it is clear that actual penile penetration of the pre-pubertal vagina without severe trauma is not possible”

• Do you agree or disagree and why?
• “Injuries that penetrate through the hymen into the underlying vaginal tissue or penetrating injuries to the fossa navicularis or the posterior fourchette will result in scarring or visible histological verifiable scarring that can be seen under the microscope”

• Do you agree or disagree and why?
• “if there has been forceful penile penetration of the hymen there will be both a history of pain and bleeding and healed evidence of this forceful penetration”

• Do you agree or disagree and why?
Anal findings in children with and without probable anal penetration: A retrospective study of 1115 children referred for suspected sexual abuse

Arne K. Myhre\textsuperscript{a,b,\ast}, Joyce A. Adams\textsuperscript{a}, Marilyn Kaufhold\textsuperscript{a}, Jennifer L. Davis\textsuperscript{a}, Premi Suresh\textsuperscript{a}, Cynthia L. Kuelbs\textsuperscript{a}
Fig. 2. Eleven year old girl showing midline anal fissure and total anal dilatation with stool that developed during the examination. She had a history of several episodes of anal penetration and was examined non-acutely in prone knee chest position.
Conclusions

• Positive association between anal penetration and:
  ▫ Anal soiling
  ▫ Anal fissure
  ▫ Anal laceration
  ▫ Total anal dilatation

• Limitations: no control for knee-chest position, length of time in knee chest, hx of anal penetration – always examined in knee chest
You have been asked for an opinion:

- The following statement facts were provided for comment:
- On 3 occasions, Aaron (7-8 yrs old at the time) alleges that the Accused had anally penetrated Aaron with his penis – once and then several months later, twice during the same evening. He did not struggle during any of these incidents. No lubrication was used. After it occurred, Aaron described having the sensation of having to go to the bathroom. No blood was noticed, and the level of discomfort was described as only ‘slightly painful’. Aaron was taken to his family MD after he disclosed a few days after the last incident. The family MD documented: patient examined in lateral position “anal dilation was noted”.
Your request was the following: “what physical results and degree of pain one would reasonably expect to see in a child who has reported anal penetration.

Would it be either expected or unusual that there not be any blood or significant degree of discomfort?”

Can you comment on the significance of the finding: anal dilatation
Prevalence and Characteristics of Youth Sexting: A National Study
Kimberly J. Mitchell, David Finkelhor, Lisa M. Jones and Janis Wolak
Pediatrics 2012;129;13; originally published online December 5, 2011;
DOI: 10.1542/peds.2011-1730
Conclusions

**FIGURE 1**
Types of sexting involvement (percentages based on $N = 1560$).
• “Sexting may not indicate a dramatic change in youth risk-taking or youth sexual behaviour”
• “It may just make some of that behaviour more visible to adults and other authorities”
• “Data suggests that appearing in, creating, or receiving sexual images is far from being a normative behaviours for youth”
Questions

• Based on these results would you include sexting in your assessment for sexual assault / abuse

• If so, how would you articulate the question to determine sexting behaviour and whether or not it was of concern
Original article

Sexting, Substance Use, and Sexual Risk Behavior in Young Adults

Eric G. Benotsch, Ph.D., Daniel J. Snipes, Aaron M. Martin, M.S., and Sheana S. Bull, Ph.D.
Conclusions

• “sexting is robustly associated with high-risk sexual behaviour.”
• “Sexting was reported by 44% - more likely to report recent substance use and high-risk sexual behaviours, including unprotected sex and sex with multiple partners, and higher rates of STI”
Questions

• How do the results of this study impact the assessment in sexual assault care of youth?

• Should practitioners be assessing high risk behaviour of youth? How would they do this ie. what questions would you ask?