

CHILD SEXUAL ABUSE: FACTS, MYTHS, AND STI'S

Judy Guinn MD

Children's Hospital of Wisconsin
Child Abuse and Protection Services

DISCLOSURES

I DO NOT have any relevant financial interest or other relationship(s) with a commercial interest producing health-care related product and/or services to disclose.

FAST FACTS

- Child sexual abuse is common!
 - 1 out of 4 females
 - 1 out of 7 males
- Perpetrator is usually a family member or acquaintance (90%)
- Child sexual abuse is usually not a violent act, involves grooming process
- Children do not usually disclose sexual abuse immediately after the assault, often wait until prompted, often give partial disclosure.

MEDICAL EVALUATION OF CHILD SEXUAL ABUSE

- History
 - Medical history
 - Forensic interview
 - Investigation
- Physical exam
 - Head to toe exam
 - Anogenital exam-colposcope
- Lab
 - STI testing
 - Urine pregnancy test as indicated
- Assessment-putting it all together
- Plan
 - Mental health services
 - Medical treatment as indicated

CSA MYTHS



A COLPOSCOPIC ANOGENITAL EXAM IS INVASIVE AND TRAUMATIC TO A CHILD.

- Majority of SA exam involves viewing external anogenital structures
- Speculum exam done only when medically indicated
 - Bleeding and unable to detect source
 - Adolescent sexual assault collection
 - General anesthesia used in prepubertal children needing speculum exam
- Trauma informed care approach
- Role of Child Life Specialist
- Reassurance of normal

A NORMAL ANOGENITAL EXAM MEANS “NOTHING HAPPENED”.

- Multiple studies show that the majority of children evaluated for sexual abuse have normal or nonspecific exams.
 - Examination findings in **legally confirmed** child sexual abuse: it's normal to be normal – Adams, 1994: Abnormal findings in 14%, suspicious findings in 9% of cases.
 - Children referred for possible sexual abuse: Medical findings in 2384 children evaluated for sexual abuse- Heger, 2002: 95% of exams were normal or nonspecific, 6% abnormal with disclosure of penetration, 4% abnormal with no disclosure of penetration.
 - Genital anatomy in pregnant adolescents “Normal” does not mean “nothing happened” – Kellogg, 2004: Only 2 out of 36 subjects had definitive findings for penetrating trauma.
 - Anogenital Findings in 3569 Pediatric Examinations for Sexual Abuse/Assault – Smith, 2018: Diagnostic findings for sexual contact present in 4.8% of patients, 14.2% with exam within 72 hours, 13.9% with adolescents.
- Predictors of abnormal anogenital findings: Female, History of pain and/or bleeding with assault, age (adolescents), time since most recent abusive contact (acute assault), disclosure of penetration

WHY?

- Length of time between abuse and disclosure
- Resiliency of anogenital tissues
- Rapid healing
- Nature of sexual contact

A MEDICAL EXAM IS NOT NEEDED IF THERE WAS NO "PENETRATION".

- NCA Medical Standard:
 - All children who are suspected victims of child sexual abuse are entitled to a medical evaluation by a provider with specialized training. The collection and documentation of possible forensically significant findings are vital. However, the referral of children for medical examinations should NOT be limited to those for which forensically significant information is anticipated.
- Partial disclosure is the rule in children, especially younger children
- Is a child able to communicate that penetration occurred?
- Legal definition of penetration

IN ACUTE SEXUAL ASSAULT EXAMS IN CHILDREN, MOST FORENSIC EVIDENCE IS FOUND ON GENITAL SWABS.

- Forensic Evidence findings in prepubertal victims of sexual assault – Christian
- 273 children, mean age 5.3 years, seen acutely in ER, rape kit done
- 23 % had anogenital injuries
 - 88% with injury seen within 24 hours
 - 55% lacerations, 38% abrasions, 7% bruises
 - Increased likelihood of finding forensic evidence
- Forensic evidence found in 24%
 - 64% forensic evidence on linens or clothing
 - only collected 35% of time
 - All evidence found within 44 hours of assault
 - Semen found in 32% with hx ejaculation, but also in 12 who denied ejaculation

FORENSIC EVIDENCE

- Clothing/linens should be pursued vigorously for analysis
- See children promptly after complaint of acute sexual assault to collect evidence, document injuries which heal rapidly
- Do not rely completely on child's history of assault when deciding to collect forensic evidence
- Collect forensic evidence if genital injury

A SEXUAL ASSAULT EVIDENCE EXAM SHOULD NOT BE CONSIDERED BEYOND 72 HOURS AFTER THE ASSAULT

- Adolescents are an exception
 - Sexual contact more likely to involve "penetration"
 - Forensic evidence (semen, sperm) can be found in endocervix for longer period of time
 - Pregnancy prophylaxis can be given up to 5 days post-assault
 - STI prophylaxis can still be given, with exception of HIV PEP
 - Consider evidence collection up to 120 hours post-assault in this population

MEDICAL PROVIDERS SHOULD NOT QUESTION KIDS ABOUT SEXUAL ABUSE.

- Medical History
 - Helping role of physicians and nurses: child may disclose to medical provider information not shared with investigators.
 - May uncover physical symptoms related to sexual abuse incident.
- Minimal Facts needed to make reporting decision
 - Who
 - What
 - When
 - Where
- Court testimony
 - Excited utterance
 - Medical history

SEX TRAFFICKING IS RARE IN WISCONSIN

- Homicide Review Commission Reports - Milwaukee
 - 2013: 77 victims ages 12-17 identified between 2010-2012
 - 2018: 231 victims identified between 2013-2016
 - 55% under the age of 18
- Milwaukee Child Advocacy Center
 - 11% of youth screened had been exploited

Marshfield Police Department Helps with Human Trafficking Bust

Thursday, September 14, 2017 4:18 p.m. CDT

UNDATED (WSAU-WDLB) -- The Marshfield Police Department was one of 20 law enforcement agencies participating in a statewide sting operation to arrest more than two-dozen sex traffickers, "johns" and child abusers this summer.

State Attorney General Brad Schimel announced the arrests Thursday, as part of the launch of his new Bureau of Human Trafficking. 25 individuals were apprehended in July and August, in a sting operation targeting those seeking children for sexual purposes in northern central and eastern Wisconsin. Some of those arrested were knowingly seeking 14-and-15-year-olds for sexual reasons. Charges include soliciting a prostitute or child for prostitution, pandering, attempted second-degree sexual assault of a child, child enticement, using a computer to facilitate a sex crime, and exposing a child to harmful materials.

Other agencies involved included the Juneau County Sheriff's Office, Sheriff's and D-A offices from Door, Dane, Rock, Sheboygan and Vilas Counties, and police departments in Madison, Monona, McFarland, Kohler, Cottage Grove, and Eagle River—along with U-S Marshals and the State Patrol.

2015 Sex Trafficking in Wisconsin & the U.S.

Sex trafficking exists throughout Wisconsin

Sex trafficking is a modern-day form of slavery in which a commercial sex act is induced by force, fraud or coercion.

80% of human trafficking in Wisconsin is sex trafficking

12-14 years old Average age a child is coerced into the sex trade

250,000 In the U.S. at risk of sexual exploitation youth

Sex trafficking is a \$150 billion+ per year industry

21 million Victims worldwide: of ANY age, gender, race, religion and socioeconomic background

The enormous profit for traffickers derives from the "repeated sale" of the victim's body

Sex trafficking occurs in both urban & rural areas. The main route through Wisconsin is:

Top Industries

1. Pimp-controlled prostitution
2. Commercial-front brothels
3. Escort services
4. Pornography
5. Stripping

Where Victims are Recruited:

- The Internet
- Social Media
- School
- The Mall
- The Street / Park

MILWAUKEE >>> FOX CITIES/GREEN BAY >>> WAUSAU >>> MINNEAPOLIS

"Police who staged a raid at a Fox Valley motel in April found a 17-year-old Green Bay girl and a 14-year-old Appleton girl being sold to men for sex. The 14-year-old, who police said had seen 18 men before the arrest, would tell police that she needed money to repay a suspected pimp who had threatened her." —Green Bay Press Gazette, June 6, 2015

"It is not possible to remain indifferent before the knowledge that human beings are bought and sold like goods." —Pope Francis

10 to 15 Average number of times a victim is sold in 1 day

7 years Life expectancy after entry

Request Help / Report Tips

National Human Trafficking Hotline
1-888-3737-888
or text
"Help" to 233733 (BeFree)

Sources: Wisconsin Association for Humane and Recovery Services, Fiala, S. Shanon, Wisconsin Human Trafficking Protocol and Response Manual, U.S. Conference of Catholic Bishops, Shared Hope International, Wisconsin Department of Justice, Office of Refugee Resettlement, Milwaukee Journal Sentinel, Green Bay Press Gazette © 2015.

STIs



GENERAL CONSIDERATIONS

- Rare but important evidence of CSA
 - Gonorrhea 1.8%
 - Chlamydia 6.7%
- Social and legal implications
- Need to consider
 - History of sexual victimization
 - Characteristics of STI
 - Age of child

IMPLICATIONS OF THE STIs

TABLE 6. Implications of commonly encountered sexually transmitted or sexually associated infections for diagnosis and reporting of sexual abuse among infants and prepubertal children

ST/SA confirmed	Evidence for sexual abuse	Suggested action
Gonorrhea*	Diagnostic	Report
Syphilis*	Diagnostic	Report
HIV	Diagnostic	Report
<i>Chlamydia trachomatis</i> *	Diagnostic	Report
<i>Trichomonas vaginalis</i> *	Highly suspicious	Report
Genital herpes	Highly suspicious (HSV-2 especially)	Report
<i>Condylomata acuminata</i> (anogenital warts)*	Suspicious	Consider report-.**
Bacterial vaginosis	Inconclusive	Medical follow-up

Source: Adapted from Kellogg N. American Academy of Pediatrics Committee on Child Abuse and Neglect. The evaluation of child abuse in children. Pediatrics 2003;116:506-12.
Abbreviations: HIV = human immunodeficiency virus; SA = sexually associated; ST = sexually transmitted.
* If not likely to be perinatally acquired and rare vertical transmission is excluded.
† Reports should be made to the agency in the community mandated to receive reports of suspected child abuse or neglect.
‡ If not likely to be acquired perinatally or through transfusion.
§ Unless a clear history of autoinoculation exists.
** Report if evidence exists to suspect abuse, including history, physical examination, or other identified infections.

INDICATIONS FOR STI TESTING

- CDC MMWR Sexually Transmitted Diseases Treatment Guidelines, 2015
 - Child has experienced penetration or has evidence of recent or healed penetrative injury to the genitals, anus, or oropharynx.
 - Child has been abused by a stranger.
 - Child has been abused by a perpetrator known to be infected with an STD or at high risk for STDs (e.g., intravenous drug abusers, MSM, persons with multiple sexual partners, and those with a history of STDs).
 - Child has a sibling, other relative, or another person in the household with an STD.
 - Child lives in an area with a high rate of STD in the community.
 - Child has signs or symptoms of STDs (e.g., vaginal discharge or pain, genital itching or odor, urinary symptoms, and genital lesions or ulcers).
 - Child or parent requests STD testing.

TESTING METHODS

- Gonorrhea, Chlamydia
 - NAATs or culture of urine, vaginal, urethral, throat or rectal specimens
 - NAATs more sensitive than culture, but must be confirmed with a second NAAT targeting a different nucleic acid sequence in prepubertal children for legal/forensic purposes. No need to confirm in adolescents or adults (CDC).
 - Urine most sensitive for prepubertal children
 - Vaginal swabs slightly more sensitive in adolescents-self collect or provider collect.
- Trichomonas
 - Wet mount, culture, and/or NAAT
- HSV
 - Visual inspection, HIV PCR
- HPV
 - Visual inspection
- HIV, Syphilis, Hepatitis B and C
 - Serology
- BV
 - Wet mount

INFECTIONS CAUSED BY SEXUAL CONTACT*

- Neisseria gonorrhoea
 - Pharyngeal, genital, rectal infection
 - Must confirm positive NAAT in pre-pubertal children or when forensically significant (non-sexually active teen)
 - Perinatal transmission- eye infection in first few days of life
- Chlamydia trachomatis
 - Genital, rectal infection
 - Must confirm positive NAAT...
 - Perinatal transmission-colonization can last up to 3 years
 - Most infections are asymptomatic

INFECTIONS CAUSED BY SEXUAL CONTACT*

- Trichomonas
 - Vaginal, urethral infection
 - NAAT testing available but not well-studied in prepubertal children. Confirmation with different NAAT is possible, but expensive
 - Culture recommended by CDC, but not always available
 - Perinatal transmission-infection can last up to a year
- HIV
 - Need to exclude perinatal transmission and blood exposure
- Syphilis
 - Congenital vs Acquired

INFECTIONS CAUSED BY SEXUAL CONTACT AND BY NONSEXUAL MEANS

- History and disclosure by child are important in these cases
- HPV
 - Transmitted by sexual contact, perinatally, and non-sexual contact
 - Long incubation period – Laryngeal HPV can appear 5 years after birth.
 - Ask about maternal HPV or abnormal pap smear or others in household with warts
 - Acquisition of HPV after age 5 may be more concerning for sexual contact.
 - Evaluation: History, exam, test for other STIs, consider forensic interview, consider CPS report.
 - Indeterminate for SA
 - HPV 9 Valent vaccine
 - High risk HPV Types 16, 18, 31, 33, 45, 52, and 58
 - Lower risk HPV Types 6 and 11 anogenital warts
 - Start vaccinating at age 9
 - Only 2 doses needed if administered at 9-13 years

INFECTIONS CAUSED BY SEXUAL ABUSE AND BY NONSEXUAL MEANS

- HSV
 - Testing by culture or PCR (more sensitive and can test older lesions)
 - Type 1: Usually in oral region
 - Type 2: Usually in genital region
 - Transmission by sexual contact, contact with vesicle/fluid, saliva, auto-inoculation.
 - Possible to transmit without active lesions
 - Indeterminate for SA
- Molluscum
 - Usually non-sexually transmitted in children, easily transmitted and auto-inoculated
 - Reports of sexual transmission in adolescents and adults

STD MIMICS

- PPPN – Perianal/Perineal Pseudoverrucous Papules and Nodules
- Molluscum
- EBV
- Benign papules of adolescence
- Pearly penile papules

INFECTIONS THAT ARE NOT SEXUALLY TRANSMITTED

- BV
- Candida
- Strep

- Not all vaginal discharge is due to STD
 - Foreign body
 - Nonspecific irritation
 - Strep, shigella
 - Pinworms

ACUTE SEXUAL ASSAULT EXAMS- PREPUBERTAL

- STD prophylaxis for GC, CT, Trich generally not indicated
 - Low risk for ascending infection
 - Low risk for pre-existing infection
 - STD more forensically significant
 - Easier to get them back for follow up
 - Follow up in 2 weeks for testing, treat if indicated
- HIV PEP may still be indicated
 - Consider risk factors
 - Follow up serology in 4-6 weeks and 4 mo.

BOTTOM LINE...

- Sexually transmitted infections in children carry different levels of concern for sexual abuse, depending on the specific infection and the age of the child, as well as other risk factors.
- Not all infections “down there” are sexually transmitted.
- Consult a medical provider who is knowledgeable about child sexual abuse to help you interpret the presence of an infection or other medical condition.

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