

Position Statement

The medical evaluation of prepubertal children with suspected sexual abuse

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Abstract

Child sexual abuse is an important and not uncommon problem. Children who have been sexually abused may present to a physician's office, urgent care centre, or emergency department for medical evaluation. A medical evaluation can provide reassurance to both child and caregiver, identify care needs, and offer an accurate interpretation of findings to the justice and child welfare systems involved. Given the potential medico-legal implications of these assessments, the performance of a comprehensive evaluation requires both current knowledge and clinical proficiency. This position statement presents an evidence-based, trauma-informed approach to the medical evaluation of prepubertal children with suspected or confirmed sexual abuse.

Keywords: *Ano-genital examination; Child protection; Child sexual abuse; Forensic evidence; Sexually transmitted infections*

CASE SCENARIOS

A 3-year-old girl presents with a red genital area and a small spot of blood in her diaper is noted.... While redness is a medical condition commonly seen in children, blood can be the result of trauma or a medical condition.

A mother is worried about sexual abuse because her daughter's vaginal area looks "too open".... A 'larger' vaginal opening may be a normal variant and cannot indicate whether sexual abuse has or has not occurred.

A 7-year-old tells a teacher that his grandfather is touching his private area.... Report this interaction to child protection services and offer to examine the boy following the resulting forensic interview.

A 10-year-old girl presents for sexual abuse which occurred 48 hours ago.... Refer immediately to your local sexual assault

care centre for medical intervention and forensic evidence collection.

Child sexual abuse (CSA) is an important and not uncommon problem in Canada, and CSA concerns can present to medical care in many ways. Potentially concerning situations are described in these opening case scenarios. CSA was defined by the World Health Organization (WHO) in 2017 as "the involvement of a child or an adolescent in sexual activity that he or she does not fully comprehend and is unable to give informed consent to, or for which the child or adolescent is not developmentally prepared and cannot give consent [to], or that violates the laws or social taboos of society" (1).

A 2013 meta-analysis of the international prevalence of CSA suggested that 13% of girls and 6% of boys have experienced some form of sexual abuse involving physical contact (2). An Ontario study of adults found that 22.1% of females and 8.3%

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of males report having experienced some form of CSA (3). The adverse impacts of CSA on victims, which include substance use, mental health problems, and physical health consequences, are significant and life-long (4,5). According to Statistics Canada, there were 14,000 child and youth victims of sexual offences, a rate of 205 victims for every 100,000 children and youth, in 2012 (6). Studies have also shown that, on average, 25% to 50% of Indigenous women experienced sexual abuse as children, compared with an estimated 20% to 25% average in the non-Indigenous population (7).

Paediatric health care practitioners must understand CSA issues and, specifically, what medical assessments are required from them when a child presents with possible signs of abuse. Regardless of when abuse may have occurred, appropriate medical assessment can be reassuring for the child and caregivers involved as well as address immediate medical and mental health concerns. The comprehensive medical evaluation of a child who may have been sexually abused requires specific skills and knowledge. However, CSA-related training and experience varies widely among health care professionals, and clinical approaches to diagnosis and intervention often lack consistency and may be at odds with published guidelines. Such discrepancies are problematic because the misinterpretation of examination findings can lead to misinformation regarding the child's health and the family's understanding of the situation, with negative impacts on child welfare and criminal justice outcomes. The forensic and medico-legal importance of the medical evaluation requires consistent, evidence-based approaches to assessing and managing CSA cases.

The WHO guidelines have provided a sound evidence base for a global audience, and other CSA protocols based on expert consensus (8) have been recently updated (9,10). A review of issues specific to the Canadian health care context has yet to be published. This position statement provides guidance to Canadian health care providers who encounter prepubescent children who may have been sexually abused.

REPORTING SUSPECTED CONCERNS

Presentation of CSA signs and symptoms can vary widely. Children and families may visit a health care provider with or without specific concerns or allegations. Caregivers are often anxious about new, apparently sexualized behaviours in their child or more general behaviour changes. Concerns about 'abnormal' genital anatomy or unexplained injury, genital discharge, pain, or bleeding are common, and may also raise concerns around sexual abuse. Eliciting as much information as possible about a complaint at the first encounter can help to determine what the next assessment steps should be. Consultation with an expert in CSA can also clarify whether a child needs to be seen for an urgent or nonurgent examination. All health care providers are obligated to report any CSA

concern to the child welfare agency in the jurisdiction where the child and family live. Each province and territory has child welfare legislation (<http://cwrp.ca/legislation>), and the defined upper age limit for a child ranges from 16 to 18 years. Any individual with reasonable grounds to suspect that a child is at risk for experiencing or may already have experienced abuse must immediately share this concern, and the information upon which it is based, with child welfare authorities. The agency will then assess level of risk and urgency of intervention based on guidelines. Some clinicians are reluctant to report suspected CSA because they are unhappy with the reporting mandate or confused about confidentiality limits, anonymity, or information control (11). However, reluctance to report is always outweighed by the need to act in the best interest of children.

Some communities in Canada have established joint investigation protocols between child welfare and law enforcement agencies, where investigations and interviews are conducted collaboratively. Health care providers are still obligated to report an incident of suspected CSA to a child welfare agency because privacy legislation prevents reporting directly to law enforcement unless explicit consent is obtained. The Criminal Code of Canada guides law enforcement procedures regarding CSA-related offences. Possible offences include sexual assault, invitation to sexual touching, sexual interference, sexual exploitation, making child pornography, and child luring (<http://laws-lois.justice.gc.ca/eng/acts/C-46/>). The age of consent for sexual activity in Canada is 16 years. Exceptions are: (1) youth 12 or 13 years old can consent to sexual activity with a partner as long as the partner is less than 2 years older; and (2) youth 14 or 15 years old can consent as long as the partner is less than 5 years older. For a full review, see 'Age of consent for sexual activity in Canada' (12).

FOCAL ISSUES

Children are far more likely to be sexually abused by someone that they know, such as a family member or acquaintance, than by a stranger (13). Offenders often use 'grooming' tactics to gain access to and prepare victims for compliance with an abusive activity (14). Physical findings tend to be rare in CSA situations, due in part, perhaps, to a relative lack of violence involved and delayed disclosure. Children who have been sexually abused rarely disclose the event immediately. One study found that 75% of children did not disclose sexual abuse within the first year, and 18% waited more than 5 years to disclose (15). Delayed disclosure allows physical injuries to heal when they have occurred during abuse. Indigenous children, youth and caregivers may be especially reluctant to participate in CSA investigations or examinations because of prior negative experiences with residential school, law enforcement, or child welfare authorities.

WHO SHOULD CONDUCT MEDICAL EVALUATIONS IN CSA CASES?

One study of diagnostic accuracy in CSA medical evaluations has shown that a practitioner's training, experience, access to expert case review, and familiarity with the medical literature enhances diagnostic accuracy (16). However, while it is always ideal to have a skilled expert available to conduct CSA-related examinations, this may be unrealistic, particularly in rural or under-served communities. While RNs, nurse practitioners, and physicians can provide immediate care in such cases, caution is advised when their opinion or interpretation of findings is elicited. Health care providers should acknowledge their own level of expertise and skill when requested and be ready to consult with experts—clinicians who have advanced training, engage in continuing education on CSA, and participate regularly in case reviews (17). Expert consultants should be readily available to practitioners involved with CSA cases, to review images by phone or videoconference and to analyze medical findings whenever they may directly impact child welfare and/or law enforcement proceedings.

WHEN AND WHERE TO CONDUCT MEDICAL EVALUATIONS

When a prepubertal child discloses a recent sexual abuse event, a medical evaluation is warranted more urgently than if the disclosed event occurred more remotely (i.e., in the past few weeks, months, or years; see [Supplementary Figure 1](#)). However, in both urgent and nonurgent cases, the child should be interviewed by child welfare and/or law enforcement authorities before their medical evaluation. This may not always be possible when a community's resources are limited, but the following parameters should always be considered when scheduling examinations: when an alleged abuse last occurred, who the offender was, type of contact (e.g., genital-genital, oral-genital, genital-anal), or the presence of symptoms, such as pain, bleeding, or psychosocial effects (e.g., suicidality), that raise concerns for the child's safety.

An urgent assessment should be arranged for prepubertal children who have experienced sexual abuse within the past 72 hours, to conduct a specific health history, a physical and ano-genital examination, and to address psychosocial concerns. Potential needs to test for sexually transmitted infections (STIs), collect forensic evidence, and provide postexposure prophylaxis (PEP) (e.g., for human immunodeficiency virus [HIV]), should also be considered. Sexual abuse involving a prepubertal child that has occurred beyond the 72-hour time frame should be managed to ensure a streamlined approach to care, in collaboration with child welfare and law enforcement authorities. A forensic interview is typically conducted by child

welfare and/or law enforcement to gather information directly from the child about an alleged event.

While most acute cases are first encountered in hospital emergency departments, urgent care, or community health centres, less urgent cases can be managed in-clinic or by a Child and Youth Advocacy Centre (CYAC). The CYAC is a hub for system partners trained to respond to allegations with streamlined, child- and family-centred approaches. Regardless of location, a trauma-informed approach to care in an appropriate environment is critical to avoid re-victimization. A trauma-informed approach ensures that care providers are able to understand, recognize, and respond to the impact of the traumatic stress in situations of alleged CSA.

COLLECTING THE MEDICAL HISTORY

The medical history is different from the forensic interview. A child's medical history helps determine what type of medical examination is required and guides decision making around appropriate clinical care and interventions. When a child has been interviewed by child welfare and/or the police, their information can help guide the medical assessment, with focus on medical information that still needs to be obtained. The medical history should be gathered from a neutral nonoffending caregiver and, when appropriate, from the child. Refrain from directly questioning the child about events. Concentrate on obtaining relevant information from the neutral caregiver, without the child present. Current and past medical histories should be gathered ([Box 1](#)). Sensitive information should be collected in a way that ensures safety and confidentiality. Precautions include involving a professional interpreter when needed.

THE PHYSICAL EXAMINATION

Developing rapport, respecting privacy, and ensuring a trauma-informed child- and family-centred approach are all of utmost importance. A developmentally appropriate approach to the examination itself must be employed. Force, coercion, and/or restraint must never be used. If the child expresses reluctance or distress concerning examination, it should be deferred. Having a supportive person in the exam room, such as a neutral caregiver, is encouraged. A complete head-to-toe physical examination, with assessment of skin, growth and development,

Box 1. Current (and past) medical histories include:

- Ano-genital pain, bleeding, discharge, or itching
- Bowel and urinary symptoms
- Abdominal pain
- Changes in a child's mood, behaviours, or fears
- Current medications, allergies, and immunizations

including a sexual maturity rating (SMR), (formerly known as Tanner staging), should be conducted. SMR can be valuable when planning interventions, such as pregnancy prophylaxis and testing for STIs.

For girls, examination of the ano-genital region should occur in a supine, 'frog-leg' position, or in stirrups, to provide optimal visualization. For young children, examination performed on a caregiver's lap may provide reassurance, especially during the ano-genital exam. Initially, the external genital structures should be identified, followed by separation and gentle downward traction of the labia majora, with visualization of the hymen and peri-hymenal tissues. Make note of any abnormalities, such as bruising, redness, abrasions, or bleeding. Documentation of the genital examination should be clear and descriptive. All genital structures and the location of findings should be specific, using the face of a clock with the '12 o'clock' position being the anterior part of hymen. An internal speculum examination of the prepubescent vagina should only be performed in exceptional circumstances (e.g., when bleeding is present). CSA examinations conducted under anaesthesia or with conscious sedation are rarely indicated. In males, the penis, testes, and scrotum should be inspected for external injury or trauma, and any abnormality carefully documented. In all children, examination of the anal area should be conducted in a lateral position to allow for complete visualization of the anal opening and surrounding structures, always documenting signs of trauma, scarring, or other abnormality. A digital rectal examination or use of an anoscope is not recommended because neither can assist in identifying injuries from abuse. When internal vaginal or anal injury is a concern, immediate consultation with a CSA expert, gynecologist, or surgeon is recommended.

The use of a camera or a colposcope for photo documentation allows for expert consultation and helps avoid repeat examinations. Explicit consent for photography must be obtained from the child (when appropriate) or from a neutral caregiver. Photographs should be stored, transferred, and retained in accordance with clinic or hospital policy. Any release of photos requires careful consideration.

INTERPRETATION OF FINDINGS

Most genital examinations of children in CSA-related situations are normal or yield nonspecific findings (8,16–20). The absence of findings is best understood in context. For example, inappropriate contact may not have caused tissue injury, and the timing of last contact may have been sufficiently remote for healing to occur (8). Child welfare workers and/or the police often request the results of a genital examination, with interpretation of findings. Health care providers must be aware of their own limitations if asked to 'explain' or comment on examination

results. All practitioners should consult or refer to experts/specialist in the field. These expert/specialized clinicians will refer to current, evidence-based guidelines when asked to interpret findings (10) (Table 1). Clinicians should be aware of findings that indicate trauma or maltreatment as well as signs that can be mistaken as indicators for abuse (10).

Findings should be reviewed by a clinician with expertise in CSA or paediatric gynecology to ensure that misinterpretation does not occur (21). Furthermore, a normal physical examination does not exclude the possibility of abuse having occurred.

Table 1. Interpreting medical findings in suspected CSA cases

Physical

- 'Normal variant' findings documented in newborns or common in nonabused children (e.g., hymenal notches and bumps, intravaginal ridge, failure of midline fusion, partial dilatation of external anal sphincter)
- Findings commonly caused by medical conditions other than trauma or sexual contact (e.g., erythema, labial adhesion, anal fissures)
- Findings that can be mistaken for abuse which are caused by other conditions (e.g., urethral prolapse, lichen sclerosus, vulvar ulcers)
- Findings where there is no expert consensus regarding significance (e.g., complete anal dilatation with relaxation of external and internal anal sphincter without predisposing factors; a notch or cleft nearly to the base of the hymen at or below the '3 o'clock' or '9 o'clock' position)
- Findings caused by trauma (e.g., acute injury or signs of residual (healed) injury to genital or anal tissues). One example is a hymenal transection/complete hymen cleft—a defect in the hymen below the 3–9 o'clock location that extends to or through the base of the hymen

Infections

- Infections unrelated to sexual contact (e.g., vaginitis with organisms transmitted by nonsexual means and genital ulcers caused by viruses)
- Infections that can be spread by nonsexual as well as sexual transmission (e.g., molluscum contagiosum, HPV, HSV)
- Infections caused by sexual contact (e.g., *Neisseria gonorrhoeae*, *Chlamydia trachomatis*, *Trichomonas vaginalis*, HIV)

Diagnostic of sexual contact

- Pregnancy
- Semen identified in forensic specimens taken directly from a child's body

Adapted from reference (10).

CSA Child sexual abuse; HIV Human immunodeficiency virus; HPV Human papillomavirus; HSV Herpes simplex virus.

Written documentation should present findings in an objective manner. When a medical history and physical examination are performed by trainees, the most-responsible physician or care provider should also be present and co-sign the report.

FORENSIC EVIDENCE COLLECTION

In cases of acute sexual abuse, law enforcement authorities may request collection of forensic evidence. A 'sexual assault evidence kit' is generally provided by local police or the RCMP. However, evidence collection should be conducted by a health care professional. Such kits include clear instructions to guide clinicians who do not collect evidence on a regular basis. While most positive results are obtained within 24 hours of an alleged sexual assault (22), recent guidelines suggest that, in some cases, collecting evidence up to 72 hours in prepubescent children may be warranted (23). Considerations for collecting evidence beyond 72 hours will depend on case details and jurisdictional guidelines. When the exchange of bodily fluids is suspected, genital and skin swabs should be collected, as well as clothing and linens, if available. Consent should be obtained from the child (if appropriate) and/or a caregiver before collection, and all evidence must remain with the examiner until sealed, then maintained securely until it is handed directly to police.

SEXUALLY TRANSMITTED INFECTIONS (STIs)

An STI from sexual abuse is rare in prepubescent children in Canada (24). In a study of 563 female child victims of suspected sexual assault, the incidence of *Chlamydia trachomatis* (CT) was 3.1%; for *Neisseria gonorrhoeae* (NG), it was 3.3% (25). Given the rarity of CSA-related transmission in this population, testing for STIs should be considered on a case-by-case basis and guided by Public Health Agency of Canada recommendations (24). Various testing methods for STIs exist, including culture, nucleic acid amplification tests (NAATs), and serology. In prepubescent children, culture for NG and CT has been the preferred testing method for medical–legal purposes. However, NAATs may be acceptable if positive results are confirmed by a second set of primers or, in some cases, a second test sent to a different laboratory (24). A urine NAAT test, using 10 to 20 mL of first catch urine, is an ideal, noninvasive way to obtain NG and CT specimens. Testing specific sites (i.e., vaginal/urethral/anal/pharyngeal) is based on the point of sexual contact indicated by the history, the timing of potential exposure, and whether signs or symptoms are present. If a site of contact has not been identified, the intrusiveness of the testing method and risk for transmission of infection must be weighed, and testing may be deferred.

Prophylaxis or empiric treatment of STIs is not typically recommended for prepubertal children in the acute setting,

especially if they can return for full STI testing in a follow-up clinic. By offering prophylaxis, the practitioner may inadvertently mask early infection, which can have clinical and forensic implications. If STI prophylaxis and/or acute testing are not completed, follow-up in 1 to 2 weeks for STI testing is recommended.

HIV-PEP is recommended for prepubescent children following acute sexual abuse when any of the following high-risk factors are present: the suspected offender is HIV-positive, significant exposure has occurred (i.e., oral, anal, or vaginal penetration without condom use or condom status is unknown or suspect) (24). The need for HIV-PEP should always be discussed with an expert in infectious diseases if oral, anal, or vaginal penetration has occurred within the past 72 hours. HIV-PEP should be started as soon as possible following exposure and no later than 72 hours postexposure.

When there is concern about possible transmission of hepatitis B, determine immunization status and consider initiating hepatitis B vaccine and possibly administering Hepatitis B immunoglobulin. Collect serology for hepatitis B, C and syphilis. Follow-up HIV testing should be completed at 6/12/and 24 weeks and hepatitis C testing at 12 and 24 weeks following a significant exposure (24). The Centers for Disease Control in the USA recommend postexposure vaccination with human papillomavirus vaccine (26), but this guideline has not been adopted in Canada. Whenever an STI test result is positive, results should be reviewed with an expert clinician such that appropriate repeat or confirmatory testing, additional testing, and treatment can be initiated.

PSYCHOSOCIAL ISSUES

The disclosure or discovery of CSA is typically experienced as a crisis impacting many aspects of a family's life. While there is no one symptom or cluster of symptoms that characterizes the large majority of CSA victims, post-traumatic stress reactions and some concerning sexualized behaviours are common. The implications of CSA for nonoffending caregiver(s) are also significant. A child's adjustment and long-term outcomes following sexual abuse are strongly associated with caregiver response and support (27). Having a caregiver who believes and protects the child has been correlated with more positive outcomes for victims. Interventions targeting nonoffending caregivers in the immediate aftermath of a disclosure are critical to promoting optimal outcomes (28,29)

While not all children who have experienced sexual abuse require intensive therapy, a comprehensive and careful trauma assessment by a mental health professional is crucial to identify individual needs and treatment planning. Trauma-focused cognitive behavioural therapy has been recognized as the optimal treatment modality for children who have been sexually abused and require intervention (30).

SUMMARY

Following disclosure of sexual abuse, the medical evaluation has an important role in supporting the child and family, ensuring the overall health and well-being of the child, and providing information to the child welfare and criminal justice systems. Ongoing training, review of the literature, and expert referral and consultation are the key components of competency for medical care. Research studies have found only a small percentage of physical findings in CSA cases, but published guidelines help to ensure accurate interpretation of such findings. While findings may be absent in most cases, this does not mean CSA did not occur. The child's disclosure remains the most important part of overall assessment. Collaboration with child protective authorities, law enforcement, and mental health agencies is critical to ensure that all aspects of child and family well-being are addressed. The medical evaluation is a pivotal step on a trauma-informed, evidence-based pathway toward recovery and safety.

SUPPLEMENTARY DATA

Supplementary data are available at *Paediatrics & Child Health* Online.

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