UPDATES IN SEXUAL ABUSE EVALUATION

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Outline

• Georgia Mandated Reporting law (2015)
• U. S. Department of Justice: A National Protocol for Sexual Abuse Medical Forensic Examinations – Pediatric (2016)
• “Updated Guidelines for the Medical Assessment and Care of Children who may have been Sexually Abused” Dr. Joyce Adams et. al., (2016)
• Centers for Disease Control and Prevention, “Sexually Transmitted Diseases Treatment Guidelines” (2015)
GA MANDATED REPORTING LAW

O.C.G.A. 19-7-5
Conditions for reporting

• Previously: *The following persons having reasonable cause to believe that a child has been abused shall report or cause reports of that abuse to be made as provided in this Code section...*

• Now: mandated reporters must report when they have *reasonable cause to believe that suspected child abuse has occurred.*
The amended statute includes a section clarifying that someone working within a medical or child-caring institution may report suspected abuse to a supervisor or designated contact person. Anyone following that procedure "shall be deemed to have fully complied" with the statute.

The supervisor or designated contact person then has the obligation to report the suspected abuse to child services. “Under no circumstances shall any person in charge of such hospital, school, agency, or facility, or the designated delegate thereof, to whom such notification has been made exercise any control or restraint or modification or make any other change to the initial information, but they can provide any additional, relevant and necessary information.”
How to report suspected maltreatment

• Previously: An oral report shall be made immediately, but in no case later than 24 hours from the time there is reasonable cause to believe a child has been abused, by telephone or otherwise and followed by a report in writing, if requested, to a child welfare agency providing protective services, as designated by the Department of Human Services, or, in the absence of such agency, to an appropriate police authority or district attorney.

• Now: “With respect to reporting required by subsection (c) of this Code section, an oral report by telephone or other oral communication or a written report by electronic submission or facsimile shall be made immediately, but in no case later than 24 hours from the time there is reasonable cause to believe that suspected child abuse has occurred.”

(DHS has developed a form, but it requires completion of online mandated reporter training to access it.)
A NATIONAL PROTOCOL FOR SEXUAL ABUSE MEDICAL FORENSIC EXAMINATIONS – PEDIATRIC

U. S. Department of Justice, Office on Violence Against Women
2016
DOJ Protocol – Pediatrics

• A guide for health care providers who conduct medical forensic exams and for other professionals involved in an initial community response to child sexual abuse (CSA).

• Developed in collaboration with the Int’l Association of Forensic Nurses, child abuse pediatricians, EDs, FBI, etc.

• Strong emphasis on comprehensive, coordinated community response to fully address the needs of children
Organization of the document

• A. Foundation for Response During the Exam Process
  • Focuses on guiding communities in laying a foundation of approaches and practices that support successful response during the exam process to disclosures or suspicions of CSA

• B. Exam Process
  • Focuses on components of the CSA medical forensic exam process

• Glossary and Acronyms

• References

• Appendices

• [www.Kidsta.org](http://www.Kidsta.org) for web version of protocol
Pediatric = ?

- Addresses the prepubescent child
  - Tanner stage 1 or 2

- Female children who have not reached onset of menses:
  - should be examined by health care providers specifically trained in pediatric sexual abuse.
  - Must not have a speculum exam, unless there is associated trauma requiring surgical involvement

- Tanner 3 – 4
  - They are still children; must consider developmental needs.
  - Extreme care should be taken when deciding to do a speculum exam in order to prevent further injury, pain, or trauma
Timing of Evidence Collection
Timing of Evidence Collection

- Collect forensic samples within the prescribed jurisdictional time frame
  - Which should be a *minimum window* of 72 hours since the sexual abuse

- Collection of internal vaginal and cervical swabs is *not indicated* for prepubescent children. Forensic samples are obtained from the external genital surfaces only, unless a medical necessity exists to use anesthesia.

- “Some children may benefit from forensic evidence collection beyond 24 hours, especially in jurisdictions where DNA amplification is performed as part of crime lab analysis.”
Consent for Care
Consent for Care

• A child should never be forced to undergo the medical forensic examination and/or have forensic evidence collected.

• Assent should be sought from children who are by jurisdictional definition too young to grant informed consent for care, but old enough and/or developmentally able to understand and agree with participation.
Who should pay?
Who should pay?

• Jurisdictions should explore all viable sources of funding for sexual abuse medical forensic examinations for prepubescent children. The goal is that children and their families are not charged for forensic evidence collection and have reliable sources of financial aid for related medical expenses AND that examiners and exam facilities are adequately reimbursed for their services in each case.

• The Violence Against Women Act requires states to provide forensic medical examinations to adult/adolescent victims of sexual assault free of charge (for forensic costs); this provision does not extend to medical forensic care for children <11 years of age.
Gathering information

• Medical providers should gather info necessary to address the child’s health care needs and to guide the exam and collection of forensic samples.

• The process for taking a medical history as part of medical forensic care is similar to any other medical history taking: CC, HPI, ROS, Medical/Family/Psychosocial history
  • The history subsequently guides the exam, formulation of a diagnosis, treatment and other health care interventions and discharge planning.

• Coordinate the sharing of information.
How to read a clock
How to read a clock
• Some examiners assign the 12 o’clock position to the urethra, causing the clock position to change when the child’s position changes. Others have the clock positions remain the same, and always document the position of the child when describing a finding. Each examiner should choose the method that best suits their practice and adhere to that method for each examination.

• Note the type of injury, size if possible, structure upon which the injury is observed, color of the injury, discharge, foreign bodies and/or blood.
At time of patient discharge – address the following

• Validate the child’s feelings regarding the exam and alleviate related fears

• Review generally what was done during the exam

• Provide a medical explanation of care provided, exam findings, tests administered, meds provided/prescribed, and f/u testing and care
At time of patient discharge – address the following

- Identify if there are any unaddressed immediate medical or mental health needs or concerns related to the abuse
- Discuss with the child and caregiver whether they would like a health care provider to provide a f/u call
- Begin to identify psychosocial interventions that may aid the child and/or family members
At time of patient discharge – address the following

• Review what to expect from multidisciplinary team response

• Ensure that the child has a plan for physical and emotional safety after discharge

• Provide the child and caregiver with written instructions and materials that summarize what was discussed and reinforce need for follow up
JOYCE A. ADAMS, MD, ET. AL

“Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused”

J Pediatr Adolesc Gynecol 29 (2016) 81-87
History

• 2007 guidelines and recommendations published in the Journal of Pediatric and Adolescent Gynecology
  • Review of medical literature → consensus development re interpretation of medical and lab findings in children brought in for examination for suspected sexual abuse.

• 2016 guidelines – review of recently published research and recommendations from the CDC and the AAP; searched medical literature for well-designed, unbiased studies.
  • Authors reached consensus on revision of 2007 guidelines based on literature critique and review
Timing of Medical Examinations

- **Emergency** evaluation
  - Medical, psychological or safety concerns
  - Alleged assault occurred within timeframe to collect forensic evidence
  - Need for emergency contraception
  - Need for post-exposure prophylaxis for STIs

- **Urgent** evaluation
  - Sexual contact occurring within the previous 2 weeks, without emergency medical, psychological, or safety needs identified

- **Nonemergent** evaluation
  - Abuse suspected but contact occurred >2 weeks prior without emergency needs

- **Follow-up evaluation**
  - Findings on initial exam are unclear or questionable necessitating reevaluation
  - Further testing for STIs not identified or treated during the initial exam
  - Documentation of healing/resolution of acute findings
  - Confirmation of initial examination findings, when initial exam was performed by an examiner who had conducted fewer than 100 such evaluations
• **Documentation**
  - Use of unambiguous language that can be understood by nonmedical professionals
  - Photodocumentation recommended as a standard of care
    - Especially if positive findings
    - Diagnostic-quality images allow for expert review for quality assurance, teaching, and legal proceedings
    - Photos never substitute for detailed, written descriptions of the exam findings

• **STI Testing**
  - Caution: This article uses the 2010 CDC Guidelines
Interpretation of Findings

• Additions
  • A section on *conditions that are often erroneously attributed to sexual abuse trauma*

• Deletions
  • *Flattened anal folds* were removed from “findings commonly caused by medical conditions other than trauma or sexual contact” because no studies have addressed the association of flattened anal folds with sexual contact.
  • The language “anal dilatation to <2 centimeters” was removed since the significance of anal dilation of a certain size is unknown.
  • The “Indeterminate” category has been relabeled as “No Consensus” regarding the significance of a particular exam finding for sexual abuse.
    • “Indeterminate” was often misinterpreted by clinicians to mean case information is insufficient or inadequate. The lack of expert consensus does not mean that there is no scientific evidence regarding the findings in this category.
Categories of Findings

• Findings Documented in Newborns or Commonly Seen in Nonabused Children
• Findings With No Expert Consensus on Interpretation With Respect to Sexual Contact or Trauma
• Findings Caused by Trauma and/or Sexual Contact
Findings Documented in Newborns or Commonly Seen in Nonabused Children

• **Normal Variants**

  • Any notch or cleft of the hymen (regardless of the depth) above the 3 and 9 o’clock locations
  
  • Superficial notches of the hymen at or below the 3 and 9 o’clock locations
Findings Documented in Newborns or Commonly Seen in Nonabused Children

- Findings commonly caused by medical conditions other than trauma or sexual contact

- Molluscum contagiosum
Findings Documented in Newborns or Commonly Seen in Nonabused Children

Conditions mistaken for abuse

• Visualization of the pectinate/dentate line at the juncture of the anoderm and rectal mucosa

• Partial dilatation of the external anal sphincter, with the internal sphincter closed, causing the appearance of deep creases in the perianal skin

• Red/purple discoloration of the genital structures (including the hymen) from lividity post-mortem, confirmed by histological analysis
Findings With No Expert Consensus on Interpretation With Respect to Sexual Contact or Trauma

• Notch or cleft in the hymen rim, at or below the 3 or 9 o’clock location, which is deeper than a superficial notch and may extend nearly to the base of the hymen, but is not a complete transection. Complete clefts/transections at 3 or 9 o’clock are also findings with no expert consensus in interpretation.

• Genital or anal condyloma acuminatum in the absence of other indicators of abuse; lesions appearing for the first time in a child older than 5 years may be more likely to be the result of sexual transmission.
Findings caused by trauma and/or sexual contact

- Injuries indicative of acute or healed trauma to the genital/anal tissues
  - Bruising, petechiae, or abrasions on the hymen
  - Vaginal laceration
  - Perianal laceration with exposure of tissues below the dermis
  - Healed hymenal transection/complete hymen cleft – a defect in the hymen between 4 o’clock and 8 o’clock that extends to the base of the hymen, with no hymenal tissue discernible at that location
  - A defect in the posterior (inferior) half of the hymen wider than a transection with an absence of hymenal tissue extending to the base of the hymen
Findings caused by trauma and/or sexual contact

- Infections transmitted by sexual contact, unless there is evidence of perinatal transmission or clearly, reasonably and independently documented but rare nonsexual transmission
  - Genital, rectal or pharyngeal *Neisseria gonorrhoeae* infection
  - Syphilis
  - Genital or rectal *Chlamydia trachomatis* infection
  - *Trichomonas vaginalis* infection
  - HIV, if transmission by blood transfusion has been ruled out
Expert Review of Exam Findings

• Studies suggest and/or show that:
  • Inexperienced examiners are far more influenced by the history than are more experienced examiners in assessing examination findings
  • An experienced examiner provides more consistent and objective interpretation of examination findings.
  • Variability in interpretation of such findings appears to be linked to level of training, profession, experience and knowledge of the literature

• Remote expert consultation
  • myCaseReview: secure web-based telehealth product; images submitted for review by a medical panel of board-certified child abuse pediatricians
CDC

Sexually Transmitted Diseases Treatment Guidelines, 2015
Updated from 2010 Treatment Guidelines

- A source of clinical guidance rather than prescriptive standards
- Developed by CDC staff, representatives from federal, state and local health departments; public and private sector clinical providers, clinical and basic science researchers and numerous professional organizations.
  - Further reviewed by an independent panel of public health and clinical experts prior to final CDC approval
- Expedited Partner Therapy (www.cdc.gov/std/ept)
  - Dispensation to, or use by, a patient does not expressly preclude subsequent provision of drugs to a partner. There is no statutory requirement that a physician conduct a physical examination prior to dispensing a drug for use by a partner
Adolescents and Adults

• An initial exam might include the following procedures:

  • NAATs for *C. trachomatis* and *N. gonorrhoeae* at sites of penetration or attempted penetration

  • *NAATs from a urine or vaginal specimen or DNA probe from a vaginal specimen for T. vaginalis*

  • Serum sample for evaluation of HIV, Hepatitis B and syphilis infections

• *new comment*
Adolescents and Adults

- The following routine presumptive Rx after a sexual assault *is recommended:
  - Empiric antimicrobial regimen for chlamydia, gonorrhea and trichomonas
  - Emergency contraception considered
  - Postexposure hepatitis B vaccination if hepatitis status of the assailant is unknown and the survivor has not been previously vaccinated. *survivors who were previously vaccinated but did not receive postvaccination testing should receive a single vaccine booster dose.

- *HPV vaccination is recommended for female survivors aged 9-26 years and male survivors 9-21 years. The vaccine should be administered to sexual assault survivors at the time of the initial exam, and follow-up dose administered at 1-2 months and 6 months after the first dose.

Individualized approach to HIV PEP
FIGURE. Algorithm for evaluation and treatment of possible nonoccupational HIV exposures

Substantial exposure risk

≤72 hours since exposure

Source patient known to be HIV-positive

nPEP recommended

Substantial Risk for HIV Acquisition

**Exposure of**
vagina, rectum, eye, mouth, or other mucous membrane, nonintact skin, or percutaneous contact

**With** blood, semen, vaginal secretions, rectal secretions, breast milk, or any body fluid that is visibly contaminated with blood

**When** the source is known to be HIV-positive

Negligible exposure risk

>72 hours since exposure

Source patient of unknown HIV status

Case-by-case determination

Negligible Risk for HIV Acquisition

**Exposure of** vagina, rectum, eye, mouth, or other mucous membrane, intact or nonintact skin, or percutaneous contact

**With** urine, nasal secretions, saliva, sweat, or tears if not visibly contaminated with blood

**Regardless** of the known or suspected HIV status of the source

888-448-4911 National Clinician’s Post Exposure Prophylaxis Hotline (PEP Line)
Adolescents and Adults

Recommended Regimens for Antibiotic Prophylaxis

- Ceftriaxone 250 mg IM x 1
  PLUS
- Azithromycin 1 g PO x 1
  PLUS
- Metronidazole 2 g PO x 1 OR Tinidazole 2 g PO x 1

(Note: NO Cefixime)
TRANSGENDER INDIVIDUALS

- Persons who are transgender identify as a gender that is not congruent with the sex they were assigned at birth. Transgender women ("trans-women" or "transgender male to female") identify as women but were born with male anatomy. Similarly, transgender men (also referred to as "trans-men" or "transgender female to male") identify as men but were born with female anatomy.

- Gender identity is independent from sexual orientation.

- Clinicians should assess STD- and HIV-related risks for their transgender patients based on current anatomy and sexual behaviors.
Sexual Assault or Abuse of Children

- The identification of sexually transmissible agents in children beyond the neonatal period **strongly** suggests sexual abuse.

- Genital Herpes was changed from “suspicious” to “**highly suspicious (HSV-2 especially)**” with continued advice to report to the agency in the community mandated to receive reports of suspected child maltreatment unless a clear history of autoinoculation exists.
Sexual Assault or Abuse of Children

- “Because STDs are not common in prepubertal children or infants evaluated for abuse, testing all sites for all organisms is not routinely recommended. Factors that should lead the physician to consider screening for STDs include:
  - 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 is at high risk for 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
  - Child or parent requests STD testing
Child Sexual Abuse: lab result interpretation

- If the initial exposure was recent, the infectious organisms acquired through the exposure might not have produced sufficient concentrations of organisms to result in positive test results or examination findings.

- Alternatively, positive test results following a recent exposure might represent the assailant’s secretions but would nonetheless be an indication for treatment of the child.
Child Sexual Abuse: Trichomonas detection

- The following tests should be performed during the initial exam:
  - Culture for *T. vaginalis* infection and wet mount of a vaginal swab specimen for *T. vaginalis* infection

- Testing for *T. vaginalis* should not be limited to girls with vaginal discharge if other indications for vaginal testing exist, as there is some evidence to indicate that asymptomatic sexually abused children might be infected and might benefit from treatment.

- Data on use of NAAT for detection of *T. vaginalis* in children are too limited to inform recommendations, but no evidence suggests that performance of NAAT for detection of *T. vaginalis* in children would differ from that in adults.
Child Sexual Abuse: HPV

- The Advisory Committee on Immunization Practices (ACIP) recommends vaccination of children who are victims of sexual abuse or assault at age ≥ 9 years who have not initiated or completed immunization. Although HPV vaccine will not protect against progression of infection already acquired or promote clearance of the infection, the vaccine protects against vaccine types not yet acquired.
AAP CLINICAL REPORT

“Child Sex Trafficking and Commercial Sexual Exploitation: Health Care Needs of Victims”

*Pediatrics* 135 (3) March 2015, 566-574
Risk Factors for CSEC*

- 12-16 years of age. Female > Male?
- Family dysfunction
- Victims of child maltreatment
- History of juvenile justice or CPS involvement
- LGBTQ
- Substance use problems
- Behavioral and/or mental health problems; learning disabilities
- Girls in gangs
- Children living in regions of increased crime, adult prostitution, or areas with transient male populations (e.g., military bases, truck stops, conventions centers)

*Commercial Sexual Exploitation of Children*
Potential Indicators of CSEC – Initial Presentation

- Child accompanied by domineering adult who does not allow child to answer questions
- Child accompanied by unrelated adult or by other children and only one adult
- Child provides changing information regarding demographics
- CC is acute sexual assault or acute physical assault
- CC is suicide attempt
- Child is poor historian or disoriented from sleep deprivation or drug intoxication
Potential Indicators of CSEC – Historical Factors

- Multiple STIs or previous pregnancy-abortion
- Frequent visits for emergency contraception
- Chronic runaway behavior
- Chronic truancy or problems in school
- History of child maltreatment
- Involvement of CPS or involvement of Dep’t of Juvenile Justice
- Significantly older boyfriend
- Frequent substance use/misuse
- Lack of medical home and/or frequent ED visits
Potential Indicators of CSEC – Physical Findings

- Evidence suggestive of inflicted injury
- Tattoos (sexually explicit, of man’s name, gang affiliation)
- Signs of substance misuse
- Expensive items, clothing, hotel keys
- Large amounts of cash
- Poor dentition or obvious chronic lack of care
Conclusions and Guidelines for Pediatricians

• Be alert to the possibility that victims may present for a variety of complaints, and they rarely self-identify.

• Evaluation can be challenging. Use nonjudgmental, open attitude. Be honest/clear about confidentiality limits and role as a mandated reporter.

• Be attentive to the youth’s safety and potential distress at the interview.

• Address acute and chronic problems

• Providers may advocate for victims by:
  • Educating child-serving professionals and families
  • Anticipatory guidance re internet safety and common recruitment scenarios
  • Advocate to change state laws so that minors are treated as victims and not as juvenile offenders
Score 81 = Final Grade B

- Criminalization of Domestic Minor Sex Trafficking: 10/10
- Criminal Provisions Addressing Demand: 24.5/25
- Criminal Provisions for Traffickers: 15/15
- Criminal Provisions for Facilitators: 5/10
- Protective Provisions for the Child Victims: 17/27.5
- Criminal Justice Tools for Investigation and Prosecution: 9.5/15