

PEDIATRIC READINESS PROGRAM EDUCATION SESSION



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Managing child sexual abuse in the ED:
*Oh *\$#&%*! What am I supposed to do now?!*

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None of the planners and faculty for this educational activity have relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, reselling, or distributing healthcare products used by or on patients.

Definition

- Interaction in which the child is used for the sexual gratification of the perpetrator
 - Contact and non-contact behaviors
 - Voyeurism
 - Exhibitionism
 - Exposing child to pornography
 - Photographing a child

Victims

- Before age 18:
 - 1 out of 4 girls
 - 1 out 6 boys
 - Most vulnerable between ages 7 and 13
 - 25% are 12 to 17 years of age
 - Oregon 2023
 - 1,185 children (11% of total child maltreatment victims)
- <https://cwoutcomes.acf.hhs.gov>

Myth



Perpetrators

- Relationship to victim

- Family member 25% to 30%
- Social network 60%
- Unknown to child 10% to 14%

- One-third of adult offenses against juveniles involve “compliant victims” or “statutory sex offenses”



Presentation

- Symptoms
 - Anogenital pain
 - Bleeding
 - Discharge
 - STI
 - Pregnancy

Presentation

- Behavior changes
 - Depression, anxiety
 - Self-harm
 - Personality change
 - Socially withdrawn
 - Sleep disturbance
 - Change in appetite
 - Decline in school performance
 - Sexualized behavior

Presentation

- Parental concern
 - “red bottom” complaints
 - Parent’s history of abuse in childhood
 - Custody disagreements

Disclosure of Abuse

- Disclosure is often delayed
 - Up to 75% of sexually abused children wait at least 1 year
- Disclosures may occur
 - Inadvertently
 - At times of crisis
 - After prevention education
- Initial disclosure may be incomplete
 - Usually occurs in “bits & pieces” or as “testing the water”

Disclosure of Abuse

- Factors influencing disclosure:
 - Shame, self-blame
 - Fear of consequences
 - Threats by abuser
 - Parental lack of belief
 - Family disruption

Recantation

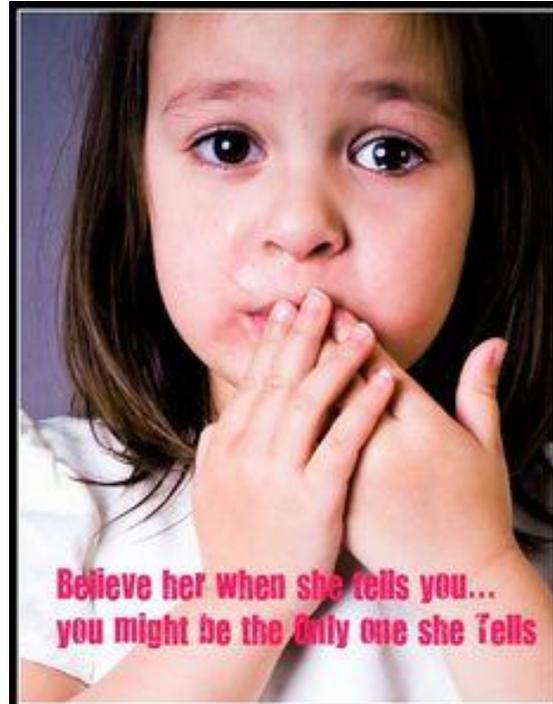
- Child discloses abuse and subsequently:
 - Denies
 - Minimizes
 - Changes peripheral details
- 12% to 33%
- Sorensen, 1991
 - 630 cases of sexual abuse (confession, plea, conviction, or medical findings)
 - 22% recanted, of which 93% later reaffirmed original disclosure

Recantation

- False allegations of sexual abuse by children are **rare**
 - Oates, 2000
 - 551 cases referred to DHS in 12-month period
 - 2.5% (14) erroneous reports
 - 3 cases of collusion with a parent
 - 3 cases of misinterpretation of innocent event
 - 8 cases of false allegation

Recantation

- Children are more likely to deny or minimize abuse rather than exaggerate or falsify (Leadership Council on Child Abuse & Interpersonal Violence)



Recantation

- Reasons:
 - Negative personal consequences
 - Protect abuser
 - Protect family from disruption
 - Lack of support from parent, family, professionals

Recantation

- Reasons:
 - Pressure to recant
 - Malloy (2007)
 - 23% recantation rate
 - Victims more likely to recant if vulnerable to familial adult influences
 - Younger children
 - Abused by parent figure
 - Lack of support from non-offending caregiver

Recantation

- Reduce risk of recantation
 - Early support for victim
 - No contact order
 - Safe placement
 - LEA and DHS support
 - Treatment

Medical Evaluation

- Goals:
 - Ensure the health and safety of the child
 - Address acute injuries
 - STI testing and prophylaxis
 - Risk of harm if sent home
 - Document injuries or other evidence of abuse
 - Forensic evidence collection
 - Photographs
 - Referral to child advocacy center
 - Mandatory reporting

Medical Evaluation

- History
 - Obtain history from parent outside the presence of the child
 - Impact on future statements by the child
 - Document the child's disclosures to the parent

Interviewing Children

- Information may be available from the caregiver, but it may also be appropriate to speak with the child
 - Children may make spontaneous disclosures to medical personnel

Interviewing Children

- Diagnostic
 - To establish a diagnosis and treatment plan
- Investigative
 - To establish a safety plan or initiate criminal investigation
- Therapeutic
 - To treat the effects of abuse

Interviewing Children

- Medical provider should obtain relevant medical history, including:
 - Symptoms
 - Physical exam findings
 - “How did you get this bruise?”
 - Type and time of contact
 - Determine need for SAFE kit

Interviewing Children

- Guidelines for questioning children:
 - Child should be interviewed in private
 - Use open-ended questions
 - “What happened?”
 - “How did you get this bruise?”
 - Avoid leading and suggestive questions
 - “Did someone hit you”
 - “Did your uncle do this?”
 - “Is this what you told your mother?”

Interviewing Children

- Guidelines for questioning children:
 - Use developmentally appropriate language, including the child's own words for his or her genitals
 - Maintain an empathetic but neutral demeanor in response to the child's statements
 - Document your questions and the child's answers verbatim, using quotation marks

Interviewing Children

- Detailed investigative interviews should be conducted by trained forensic interviewers at Child Advocacy Centers
- Forensic Interview
 - Neutral, child-friendly environment (CAC)
 - Conducted by someone with specialized training
 - Community partners watch from observation room
 - Videotaped



Physical Examination

- Exam should be performed immediately:
 - Acute injury
 - Child is symptomatic
 - Alleged sexual abuse could have occurred within 72 hours
 - Child may be unable to provide clear time frame
 - Did suspected perpetrator have access to child (opportunity) within the last 72 hours?
 - Necessary to relieve patient's or caregiver's anxiety

Physical Examination

- Genital exam may be deferred to a more child-friendly setting such as CARES Northwest:
 - Abuse could not have occurred within 72 hours
 - Child is asymptomatic
 - Family agrees

Physical Examination

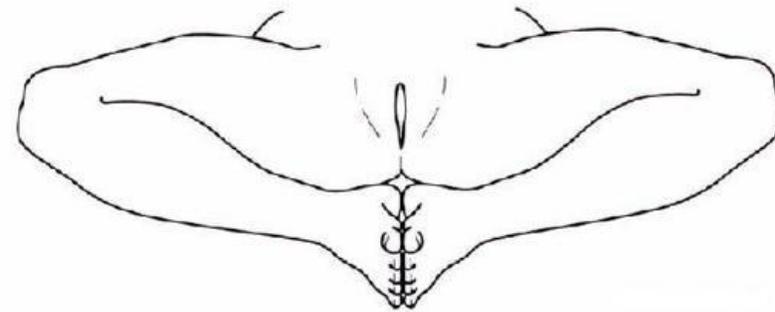
- Complete head-to-toe exam, including thorough skin exam
 - Don't just zero in on the genital exam
 - Other injuries may be present, such as those incurred in self-defense
 - Document and photograph genital injuries
 - Document and photograph other injuries

Physical Examination

- Be cognizant of child's anxiety
 - Explain what you're doing in age-appropriate language
 - Give the patient control over exam where possible
 - “Should I look in your ears first or your mouth?”
 - Take breaks as needed
 - Use toys, videos, etc, to distract patient

Female Genital Exam

- Supine Frog-Leg
 - While supine or reclining in caregiver's lap, child places soles of feet together while knees are flexed and hips are abducted



Female Genital Exam

- Labial Separation
 - Gently spread labia laterally and inferiorly



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Female Genital Exam

- Labial Traction
 - Gently grasp labia majora and gradually pull toward you until hymenal rim is visualized
 - This may help separate the edges of the hymen
 - Apply traction carefully to avoid small iatrogenic tears of posterior fourchette



DB/UTHSCSA © 1998

Female Genital Exam “Don’ts”

- In prepubertal patients, the hymen is very sensitive to touch and a swab should not be used
 - A few drops of warm saline may be used in the vestibule to “float” the hymen and help the edges unfold
- In adolescents, a cotton swab can be used to “run” the edge of the hymen to look for injuries

Physical Examination “Don’ts”

- NEVER restrain a child in order to complete the exam
 - If the child is unable to cooperate with the exam:
 - Consult with SCAN provider on call
 - Options include:
 - Rescheduling exam to CARES
 - Exam under sedation (rare)

Physical Examination “Don’ts”

- A speculum should NEVER be used during the examination of a pre-pubertal child
 - Internal vaginal exam for suspected intravaginal injuries or active vaginal bleeding:
 - Should only be performed under general anesthesia
 - After consultation with SCAN service and appropriate surgical service

What does a normal anogenital examination indicate?

- Heger (2002)
 - Prospective study of 2,384 children referred for evaluation after disclosure of sexual abuse
 - 68% of girls and 70% of boys reported penetration
 - 96% had normal examination
- Kellogg (2004)
 - 36 pregnant adolescents presenting for sexual abuse evaluations
 - Only 2 had definitive findings of penetration
 - 64% had normal or nonspecific exams

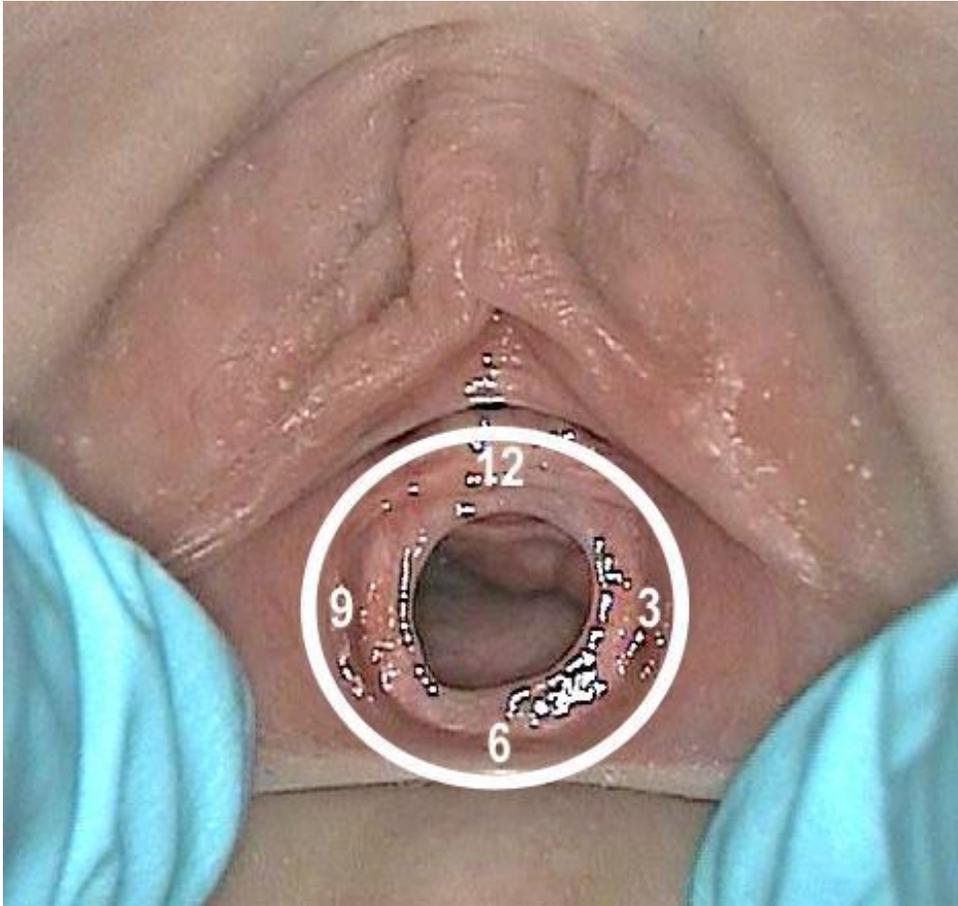
What does a normal anogenital examination indicate?

Normal does not mean nothing happened

Documentation

- Describe genital exam in sufficient detail:
 - Descriptions are more important than conclusions or interpretations
 - Photograph abnormal genital findings
 - Memorializes findings
 - Allows for peer review
 - Can be used to obtain a second opinion
 - Subsequent examiner should understand what to look for on follow-up exam

Documentation



- Clock-Face Convention:
 - Used to identify location of findings.
 - Most significant findings are located between 3 o'clock and 9 o'clock (posterior rim) in supine position

Referral to Child Abuse Specialist

- All abnormal findings must be confirmed by an experienced examiner
- Patients with equivocal or incomplete exams should be referred to an experienced examiner for further evaluation

Sexual Assault Evidence Collection Kit

- Should be considered when sexual contact could have occurred within the last 72 hours
- Kit may be modified for pre-pubertal children
 - Pubic hair combings and standards are unnecessary
 - Cervical swabs should NOT be obtained
 - Most forensic evidence in pre-pubertal children is found within the first 24 hours

Sexual Assault Evidence Collection Kit

- Instructions
 - The kit includes step-by-step instructions for collecting samples
 - Not every step will apply to every child
 - Use your judgment
 - Call SCAN on-call provider with questions
 - Note why a step was omitted on the envelope for that step

Sexual Assault Evidence Collection Kit

- Collect each piece of clothing and place in separate paper bags
 - Clothing and linens are most likely source of DNA and should always be saved and collected
 - DO NOT place in plastic; moisture will degrade DNA

Sexually Transmitted Infections

- Pre-pubertal Child:
 - Testing for STI should be considered when:
 - Perpetrator has known STI or is at high risk
 - History of another child in the home with STI
 - Child has symptoms of STI such as discharge or lesions
 - Exam findings suspicious for sexual abuse
 - Requested by parent

Sexually Transmitted Infections

- Pre-pubertal Child
 - Urine Nucleic Acid Amplification Test (NAAT) may be substituted for GC and Chlamydia cultures
 - If positive, must obtain culture or second NAAT (using different nucleic acid sequence than initial NAAT) prior to treatment
 - Culture is gold standard to establish proof of STI in court

Sexually Transmitted Infections

- Pre-pubertal Child
 - Blood:
 - RPR for Syphilis
 - Hepatitis B and C
 - HIV

Sexually Transmitted Infections

- Pre-pubertal Child
 - Follow-up
 - 2 weeks:
 - Test for GC, Chlamydia, Trichomoniasis
 - 6 weeks, 3 months, 6 months:
 - Repeat testing for syphilis, HIV and Hepatitis

Sexually Transmitted Infections

- Pre-pubertal Child
 - Treatment
 - Prophylactic antibiotic treatment is NOT routinely recommended in pre-pubertal children
 - Low prevalence of infection
 - Low risk of ascending infections
 - Unable to obtain confirmatory cultures if prophylaxis given
 - Patients are not usually lost to follow-up
 - Treat based on test results
 - See Red Book for antibiotic recommendations
 - Consult SCAN service if prophylaxis is necessary

Sexually Transmitted Infections

- Adolescents
 - All adolescents should receive comprehensive STI testing
 - High prevalence rates of STIs in adolescents
 - Increased risk of ascending infection
 - Infections are often asymptomatic
 - Identifying infection allows for notification and treatment of partners
 - Opportunity for patient education

Sexually Transmitted Infections

- Adolescents
 - Prophylactic treatment of STIs should be provided
 - High prevalence of STIs in this age group
 - Risk of ascending infection
 - Increased risk of loss to follow-up
 - Refer to Pediatric Sexual Assault Algorithm or Red Book, Table 2.16 for recommended prophylaxis

Pregnancy Testing

- Adolescents
 - All female adolescents should receive pregnancy testing and should be offered emergency contraception
 - Negative pregnancy test result is needed before prophylaxis for pregnancy
 - See Red Book, Table 2.16 for recommended regimen for emergency contraception
 - Repeat pregnancy test in 1-2 weeks

Oregon Law on Consent for STI/HIV Testing and Treatment of Minors

Oregon law ([ORS 109.640](#)) states minors 15 years of age or older can consent to most medical services without the consent of a parent or guardian.

However, minors of any age can consent to reproductive health care information and services without the consent of a parent or guardian. This includes testing and treatment for sexually transmitted infections (STIs), including HIV. ¹



Reportable conditions

Some STIs, including HIV, are [reportable conditions](#). When these conditions are diagnosed, health care providers and laboratories must report cases to the local or state health authority ([ORS 433.004](#), [OAR 333-018](#)).

Can health care providers inform a parent/guardian of a minor's STI test or treatment?

A hospital or medical provider may inform a parent or guardian of a minor's diagnosis or treatment without the consent of the minor and is not liable for advising the parent/guardian without the minor's consent ([ORS 109.650](#)). However, providers are encouraged to use their best clinical judgement in deciding whether to share information with a parent or guardian. Confidentiality and information sharing practices should be discussed with a minor patient prior to the delivery of services.

¹ The full definition of reproductive health care services can be found in [ORS 435.190](#). Limitations apply to minor consent for elective sterilization and abortion.

Local Resources



Who you gonna call?

Suspected Child Abuse and Neglect (SCAN) Team

- Team comprised of:
 - Physicians: Thomas Valvano, Tamara Grigsby, Amanda Scully
 - Social Worker
- Available 24/7 in person or by telephone
 - SmartWeb → On Call → Child Abuse
 - Physician Advice Line: 503-494-4567, prompt 3
 - OHSU main telephone number: 503-494-9000



KEEP
CALM
AND
CALL
ME

CARES Northwest



- Outpatient child abuse assessments
 - Physical Abuse
 - Sexual Abuse
 - Neglect
 - Risk of Harm
- Referrals from DHS, Law Enforcement, medical providers
- Serves Multnomah and Washington Counties
 - Similar CACs for other Oregon counties
- 503-276-9000

Thank you



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