SEXUAL ABUSE MIMICS

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Sexual abuse is difficult to diagnose since there may be no physical findings on the patient's exam to confirm the diagnosis. Often numerous other conditions mimic sexual abuse. It is important for the individuals who take care of children to become familiar with such conditions, as well as the variations of normal pediatric genital exam that can be particularly confusing for non-medical professions. In this article the author presents clinical case reports likely to be confused with sexual abuse in pediatric practice.

Key words: Child ▪ Sexual abuse ▪ Differential diagnosis

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Introduction

Sexual abuse in children is a difficult diagnosis to establish. Often there may not be any physical findings on the exam to confirm diagnosis. In addition, numerous conditions, other than abuse, may present in a similar manner, and mimic sexual abuse. It is important that healthcare workers and pediatricians in particular, become familiar with these conditions, and the variations of normal pediatric genital exam, to avoid confusion in everyday practice. In the following case reports the reader of this article assumes the imaginative role of a physician who is examining the patient.

Case 1

An eight year old white female presents with her mother to your clinic. The family has been asked by child protection to come for an evaluation. At school, the child has been noted to be frequently scratching her vaginal area. She is

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very quiet and will not talk to the teachers when they ask her if anyone has bothered her. The case was reported and child protection feels the child is at risk for sexual abuse (Figure 1).

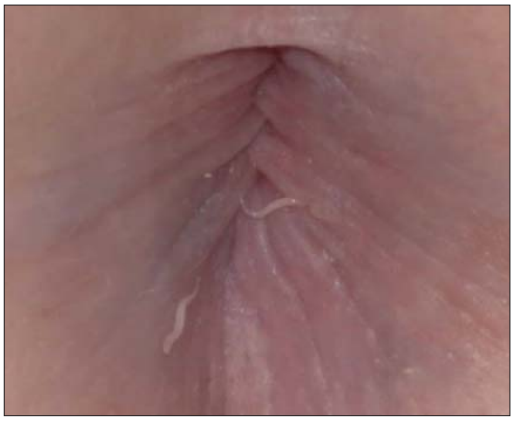

Figure 1 Pinworm
Slika 1 Dječija glista

Enterobius vermicularis is commonly known as 'pinworms'. This organism can be highly pruritic but may be asymptomatic. It is most commonly found in the grade school child (reviewer's comment: elementary school corresponds to Bosnian 'predškolsko' through 5th grade) but can infect children of all ages and adults alike. Less likely, pinworms may be responsible for more serious gastrointestinal symptoms such as obstruction, malabsorption, enteritis or appendicitis (1-3). Pinworms are easily treated with a dose of mebendazole, one 100 mg tab to be taken by each family member and a repeat treatment after two weeks. Other useful recommendations are to wash hands, keep fingernails short to minimize scratching and nailbiting, avoid sharing linens, wash linens and towels, do not share towels, frequent change of undergarments and morning bathing to wash away eggs. Other medications to treat pinworms include albendazole particularly for a child less than two years old and pyrantel pamoate for the pregnant female.

Case 2

A teacher notes that her seven year old female African American student is taking a long time in the bathroom. The little girl seems upset when she comes back to the classroom. Her teacher inquires if anything is wrong. The child responds that she has blood in her panties and it hurts to pee. The case is reported to child protection and the child is sent to you for assessment. You speak with the child one to one and she gives no disclosure. On exam you note a normal hymenal rim and a prominent donut shaped reddened area just above the vagina (Figure 2).

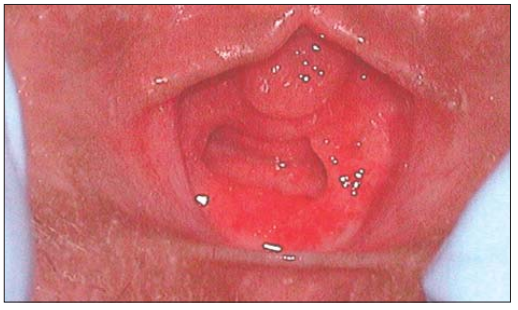

Figure 2 *Urethral prolapse*
Slika 2 *Prolaps uretre*

Genital bleeding is a concerning presentation. There are many diagnostic possibilities regarding this type of bleeding including sexual abuse. This child's diagnosis is urethral prolapse. This entity may present as four different grades, the first grade described as minimal without inflammation to the fourth grade where necrosis or ulceration is present (4). Urethral prolapse can typically be seen in young African American girls or Caucasian menopausal women. It is possibly due to low estrogen status. The child may be large for age (5). The child may also report dysuria. Treatment is typically conservative including sitz baths (reviewer's comment: 'sitz bath' corresponds to Bosnian 'kupka'), topical estrogen cream and antibiotics. Surgical correction is usually reserved for those cases

that do not respond to conservative management, those prolapses of higher grade and patients beyond puberty.

Case 3

A physician reports a case to child protection after seeing a six year old female who appears to have scattered bloody, bruised areas over the genitals. The child's grandmother accompanies the child and is concerned regarding her daughter's male visitors. One to one the child denies that anyone has touched her body. She reports that she has seen pictures of naked people when on the computer with mommy's boyfriend. They take turns looking at naked people then play a computer game. The child's grandmother reports that mom has a new boyfriend and he is always on the computer (Figure 3).

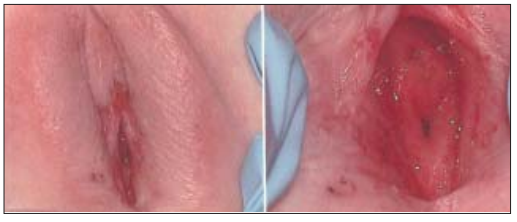

Figure 3 *Lichen Sclerosus (Photo by Melissa Hancock MD, University of Louisville, Louisville, Kentucky, USA)*
Slika 3 *Lihen sklerosus (Fotografija: Dr. Melissa Hancock, University of Louisville, Louisville, Kentucky, USA)*

This child was diagnosed with lichen sclerosus, a skin condition producing chronic inflammation. The appearance of lichen sclerosus can be impressive and mistaken for sexual abuse (6). McElland provides a descriptive clinical presentation, »…the characteristic ivory-white cigarette paper appearance of the skin in a figure of eight distribution which may be associated with fissures and purpuric hemorrhage…« (7). This sensitive skin is easily traumatized. The child may also present with genital itching, soreness and/or bleeding. Constipation or other gastrointestinal symptoms such as bleeding with stooling, soiling, and rectal fissuring may also be part of the child's history (8). Treatment requires excluding skin irritants and applying hydrocortisone cream. Higher concentrations of hydrocortisone with a tapering schedule may be necessary for effective treatment.

This case also demonstrates that while the child's lichen sclerosus is not indicative of sexual abuse there is concerning behavior occurring in the home that requires intervention. At the least, the child is a victim to sexual exposure. It is not known why the boyfriend was looking at pornography with the child. It is possible this behavior was just bad judgment on the part of the adult or could have progressed to taking sexual pictures of this child or sexually touching her at some point. Regardless, it is inappropriate sexual exposure for a juvenile and the child needs protection from this adult.

Case 4

A toddler is brought to your office for evaluation. The child was discovered to be in her father's care unsupervised, which was in violation of a safety plan previously established by child protection, and the child was removed from the home. The parents have a history of drug use and presently cannot be located. The child was temporarily placed in the care of her aunt whom she had never met until the day of placement. The aunt is very upset stating the while changing the baby's diaper she noticed there is an injury to her rectum (Figure 4).

This finding is failure of midline fusion (9). Any questionable physical finding should be re-evaluated within one week of the initial exam. This follow up is extremely helpful in delineating anatomical variants vs. sexual abuse injuries. Failure of midline fusion is

not frequently seen clinically and could be mistaken for a sexual abuse injury such as a posterior fourchette or rectal tear. Heger et al. (9) studied one hundred forty seven premenarchal girls selected for non abuse and six percent of this population had failure of midline fusion. A follow up exam will indicate that there is no change to the indicated area. Other helpful source to corroborate an anatomical variant finding is to request records; newborn and well child records can be very helpful in clarifying physical findings. As important as it is to identify the abused child, it is also crucial to not implicate a presumed perpetrator due to an incorrect or questionable diagnosis.

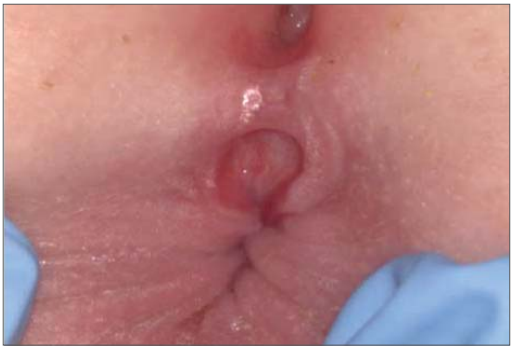

Figure 4 *Failure of Midline Fusion*
Slika 4 *Izostanak medijalne fuzije*

Case 5

A mother brings her ten year old female child to the office after discovering a discharge on the child's panties. The child has had no other signs of pubertal development to date. The child states she noticed the discharge several days prior, she has had no discomfort. She has had a cold for the last few days. You note on the exam a normal hymenal rim with some vulvar redness and cloudy discharge. You ask if you may speak with the child privately. The child has no disclosure. Speaking with the child's mother you note that the child has been spending time at her friend's house. Her friend has an older teenage brother that she has a »crush« on (Figure 5).

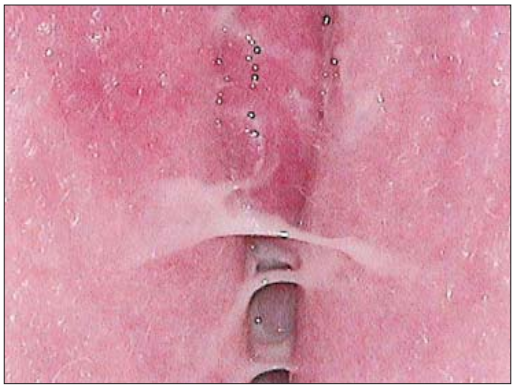

Figure 5 *Streptococcal Vaginitis*
Slika 5 *Streptokokni vaginitis*

Bacterial infections can be the causative etiology of a vaginal discharge and in this case the culture was positive for group strep A. Streptococcal vaginitis presents with vaginal redness, and discharge. Another presentation could be well circumscribed redness of the perianal area. Treatment is the same as treating streptococcal pharyngitis. Discharge in this child's age group may also be physiological. In a younger child a discharge could be the result of a foreign body. The fact that the child has a crush on her friend's brother does not necessarily imply sexual abuse.

Case 6

You receive a call from child protection regarding an 18 month old female. The daycare employee told child protection that the child 'does not look right' down there. The opening at her private area is described as 'too big' (Figure 6).

In this day and age of instant media and heightened awareness of the vulnerability of a child, it is not unusual for a daycare provider to be especially attentive to the toddler's genital area. Particularly because this child is so young she should have a medical examina-

tion as soon as feasible to assess the reported physical finding. She most likely will have a normal exam but this will just be a part of the sexual abuse assessment. The case would be reported to child protection by the school as the law requires and this will provide an opportunity to see if the family has been reported previously and if any of the reports have been substantiated. It will also be important to meet the parent or guardian and assess their present situation. It would be helpful to know if there have been other issues at school regarding the child's care or development. The parent may request that you review the case with their regular physician, promoting communication and continuity of the child's care.

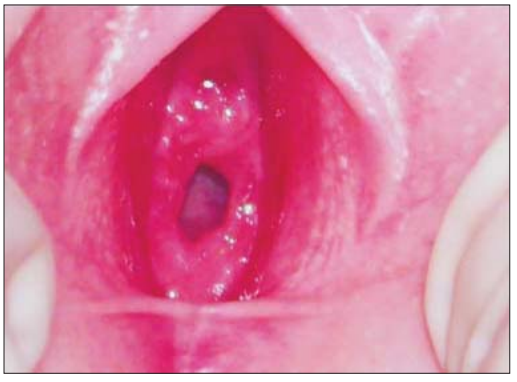

Figure 6 *Normal prepubertal female genitalia*
Slika 6 *Normalan prepubertetski izgled ženskog genitala*

Case 7

You receive a call from child protection regarding an 18 month old female. The daycare employee told child protection that the child »does not look right« down there. The daycare worker cannot see any openings in the private area (Figure 7).

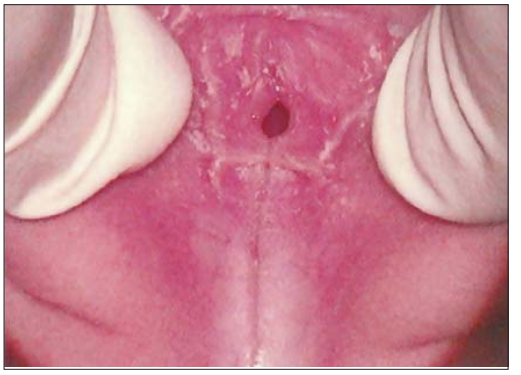

Figure 7 *Labial Adhesion*
Slika 7 *Sraščenje malih usana*

This is another example of the concerned daycare worker calling child protection based on what they feel is an abnormality, indeed this child would look different than the other little girls at diaper changing time. A labial adhesion is not uncommon in little girls in diapers and most of the time can be treated conservatively. The labia stick together or adhere creating what appears to be a covering over the vaginal area and possibly the urethral area. The possibility of sexual abuse should be part of the differential considered but an adhesion is not diagnostic for sexual abuse. Again because this is a school concern, the case would be reported to child protection and an investigation would be initiated. Treatment focuses on gentle separation of the affected area whether with use of diaper ointment down the middle or estrogen cream twice daily over the course of several weeks, then just evening use for a few weeks and discontinued once the adhesion resolves (10). Prevention of re-adhesion is promoted by using daily diaper ointment on the affected area.

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Sažetak

IMITACIJE SEKSUALNOG ZLOSTAVLJANJA

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Seksualno zlostavljanje djece se relativno teško dijagnosticira, jer fizički znakovi koji mogu potvrditi dijagnozu, pri pregledu obično nedostaju. Često različita stanja ili oboljenja mogu imitirati seksualno zlostavljanje, a postoje i značajne varijacije normalnog genitalnog pregleda, koje mogu biti zbunjujuće, posebno za nemedicinsko osoblje. Vrlo je važno da se zdravstveni radnici upoznaju sa ovim situacijama, da bi se u realnosti izbjegla moguća konfuzija. Autor u ovom radu prezentira kliničke slučajeve koji se mogu lako zamijeniti sa seksualnim zlostavljanjem u pedijatrijskoj praksi.

Ključne riječi: Djeca ▪ Seksualno zlostavljanje ▪ Diferencijalna dijagnoza

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