MATTERS ARISING

Child sexual abuse—the interface with genitourinary medicine

Whilst welcoming the increased debate about child sexual abuse (CSA) within the medical profession we were disappointed by this paper: 'There are more data concerning CSA available in the UK than presented, including the incidence (number of new cases seen each year) and prevalence (the proportion of the population which has been sexually abused at some time during childhood):' There clearly is a disparity between the two and most child sexual abuse goes unrecognised. Recent studies suggest about 1 in 2 women and 1 in 5 men have suffered some form of sexual abuse by the time they reach adulthood, and many in childhood. Five per cent of women and 2% of men have suffered serious abuse as in rape.1

Children should be seen and examined by children's doctors with appropriate training and good links with the local genitourinary medicine (GUM) clinic. In Leeds we have this model and one of our genitourinary colleagues attends our monthly peer review of colposcope slides, as we have already learned from our American colleagues. A national meeting of paediatricians interested in child abuse in the UK will be held quarterly; some colleagues are also police surgeons (Paediatricians Child Abuse Interest Group, affiliated to the BAACH and the British Paediatric Association).

Medical examinations of children who may have been abused are performed by an appropriately trained senior doctor (Consultant, SCMO or Senior Registrar). The role of the police surgeon is as indicated, for example a stranger rape. Rogers misquoted the paper prepared by the Independent Second Opinion Panel 1987 which suggested a "joint examination between a police surgeon or other appropriately qualified doctor and an experienced police surgeon may be the appropriate arrangement". As more children's doctors are trained the role of police surgeons is likely to diminish.

Rogers and Roberts description of medical history and physical findings in sexually abused children is confused. A good history, especially of any bowel or genitourinary disorder is needed and any physical signs interpreted in the light of the disorder, but clearly common disorders and sexual abuse may coexist. West in his helpful paper described the physical signs associated with accidental genital injury and the differentiation from CSA. Bays and Jendy discussed genital and anal conditions which may be confused with CSA.

There has been a recent useful paper on the examination of post-pubertal girls and boys ("all" as the effect of tampon use.2) Paediatricians have considered that the insertion of foreign bodies in the vagina of pre-pubertal girls is highly suggestive of CSA, Herman-Giddens in a recent paper confirms this.8

Rogers and Roberts have not quoted the literature concerning physical abuse and CSA; signs of physical assault are not "uncommon" but seen in around 20% of children.10 11

Bamford and Roberts12 when describing the signs of intercursal intercourse wrote "The rounded labial contour may be flattened, but it is not a reliable sign..." In the same article the comment is made that in most young children the unstretched hymenal orifice is no more than 0-5 to 0-6 cm increasing slightly as puberty approaches. The RCP Report17 states that an orifice of greater than 1 cm is not seen in normal pre-pubertal children. Has Dr Roberts changed her views since 1993?

Anal abuse in children has been described, and the association of genital and anal abuse.14 15 16 These papers are descriptive of the signs associated with abuse in English children. Rogers and Roberts are anecdotal in this paper and consequently unconvincing when reporting the signs associated with abuse without reference to the appropriate literature.

Sexually transmitted diseases are probably underdiagnosed in CSA. We found a STD in only 5%, but these were young children and most of the abuse was intra-familial. We would suggest a joint clinic with a GUM specialist may be more appropriate for teenagers. HIV infection is a complex area and we have proposed a protocol for looking at the indications for testing.14

There is a great deal of debate in the UK amongst paediatricians about CSA, there is too little research although audit is established locally. There is an increasing literature (British as well as the US) and practitioners need to use this to inform their practice.

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Family planning in genitourinary medicine

The recent papers by Masters et al and Carlin et al highlighted the need for and the benefit of providing contraception within a genitourinary medicine (GUM) clinic.12 Unlike an "opportunistric" service, setting up a designated family planning (FP) clinic can be difficult without adequate resources, or particular funding, as commented by Carlin et al. However, an alternate option may be the integration of the local FP service in the...
In conclusion, the integration of FP services within GUM with staff trained in both specialties is an alternative, cost-effective, and mutually beneficial, means of providing coordinated sexual health care for women combining contraceptive provision with STD/HIV/cervical cytology screening.

GUM clinic as experienced in our department, especially as FP practitioners have been requested to consult for collaborative efforts between the two specialties to provide a comprehensive sexual health service for women.\(^1\) On request of the GUM consultant, nearly a decade ago, Wandsworth Family Planning Services established a FP clinic in the GUM department. This arrangement has not required any additional funding from GUM, simply the provision of, initially, one female consultant, an examination rooms one morning a week and the cooperation of the clerical staff and nurses. The FP doctors and nurse, employed by Wandsworth Health Authority, have had training in GUM and can therefore provide screening for sexually transmitted diseases (STDs) using the GUM laboratory facilities. Wandsworth Family Planning Services also fund the contraceptives provided.

This setup has been mutually beneficial and a recent evaluation is awaiting publication. In general, referrals from GUM increased.\(^1\) Women requiring contraception and opting for an on-site service, in particular HIV seropositive women; post coital contraception follow ups; fittings for an intrauterine contraceptive device (IUCD) if included in FP practice; and follow up of women treated for a pelvic infection who have an IUCD. Conversely, the community based FP services use this clinic as a tertiary referral centre, particularly for patients who require an STD screen, such as women on the combined oral contraceptive pill who complain of breakthrough bleeding that may be due to infection or hormonal problems, patients with a pelvic mass, smears and smears identifying a genital infection, women who request or clinically require an STD screen before insertion of an IUCD and those with IUCD related problems, such as bleeding, pelvic pain and Actinomyces israelii infection.

This designated clinic has other advantages. It maintains the confidentiality sought by GUM patients, especially for HIV seropositive patients from confidentiality is such an important issue; it attracts patients from the local FP services who require an STD screen and are too embarrassed to attend a routine GUM clinic and the FP team can act as the resource of the health advisors for tracing contacts of patients identified with a sexual infection or counselling of patients requesting an HIV test. Furthermore, this clinic is ideal for teaching purposes. It provides on-site training of GUM doctors and nurses in family planning and training for FP doctors for the IUCD letter of competence. FP doctors and nurses in the community are also encouraged to sit in on routine GUM clinics. This increases awareness among staff of the importance of collaboration between the two specialties.

One measure of the clinic's success has been the need to expand the service as, initially only one FP doctor, now two, and still the appointments are fully booked six weeks in advance. Together with Wandsworth Community Health Trust there are plans to extend the service to three sessions a week, to include the one tertiary referral FP clinic and two other standard FP clinics, when the GUM and FP departments are relocated to a new purpose built building at the end of this decade and can therefore provide more clinic space.

Rectal gonorrhoea as an independent risk factor for HIV infection in homosexual males

We read with interest the recent study by Craib and colleagues\(^1\) who demonstrated an association between HIV seroconversion and rectal gonorrhoea in homosexual men.

Because of the shared risks of sexual behaviour for both conditions\(^2\) and methodological problems, it has not been possible to show that the relationship between sexually transmitted diseases (STDs) and HIV transmission is causal although this is believed to be the case.\(^3\) We studied the association between non-ulcerative STDs and HIV seroconversion retrospectively in homosexual men attending the Department of Genitourinary Medicine in Bristol and our findings are in agreement with Craib and colleagues and add further support to the belief that STDs facilitate the transmission of HIV. This has important implications for health intervention programmes in homosexual men.

All homosexual HIV antibody positive men, up to February 1994, who had a previous negative test were identified; these were matched with controls who had had a negative test, for age and date of the case's positive test. Twenty cases and 40 controls were identified.

No information was available on frequency of anal intercourse or number of partners per year. To attempt to reduce the confounding effect, risk sexual behaviour for both STDs and HIV we categorized sexual behaviour into higher and lower risk groups according to whether the relationship was open or closed respectively. Men who had more than one sexual partner at any given time were recorded as being in an open type relationship, and men who were documented to have a (serial) monogamous relationship were considered to be in a closed type relationship.

The following was recorded from the notes: age, dates of the positive and last negative test for the cases and date of test for the controls; type and number of STDs. Condom usage which was recorded as always, sometimes or never.

The median age of cases was 26 years (range 17–37); this was not statistically different from the controls. The median test interval was 20 months (range 1–61), in the controls the mean difference from the matching test date was 5·45 months (SD 6·23).

There was shown to be no difference in incidence of hepatitis B or syphilis between the two groups. Two (10%) of 20 cases and three (7·5%) of 40 controls had had hepatitis B. One (5%) of 20 cases and no controls had had syphilis. None of the index patients acquired these infections during the study period.

To assess the role of STDs in facilitating HIV infection we considered only those which are present on the genital epithelium/mucosa that is, gonorrhoea, genital warts, genital herpetic and non-specific urethral. STDs were recorded during the study period for patients and for an equivalent time period for the controls. We considered all patients with no documented history of an STD infection as being "negative" and four controls showed a significant relationship with risk of seroconversion (p < 0·01). Information on STDs was not available in eight of the index patients since their negative HIV test. Six (30%) of 20 cases and (30%) of 40 controls had had at least one STD. Open relationship type also carried a significant increased risk of seroconversion (p < 0·02). Sixteen (80%) of 20 cases and 18 (45%) of 40 controls were in the high risk group.

In order to control for the confounding factor that males in open relationships are theoretically more likely to become infected with STDs and HIV we carried out a Mantel-Haenszel multivariate analysis which were independently associated (odds ratio = 5·91 CI 1·43–24·5) with HIV seroconversion as was open type relationship (odds ratio = 8·41 CI 1·32–53·4).

Use of condoms was not statistically significant between cases and controls. Information was not available in two index patients and four controls. Of the index patients two (11%) always used condoms, three (15%) sometimes used condoms and one (5%) never used them compared with three (8·3%), six (17%) and 27 (75%) respectively of the controls.

While this is a retrospective study and the low use of condoms might not reflect current sexual behaviour there is evidence that risk behaviour among young homosexual men is still high despite on-going HIV prevention programmes.\(^4\) New approaches are therefore urgently needed. Much interest is currently focused on the prevention, treatment and control of STDs as a means of reducing HIV transmission in heterosexual populations from the developing world. Our findings support the conclusion of Craib and colleagues that health intervention programmes are needed which are designed to control gonorrhoea. In addition they suggest that these programmes should also be directed at other biological need to provide support for the continued development and expansion of such programmes in all sexually active individuals.

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