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, included 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 is 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 appropriate police surgeon is required as indicated, for example a stranger rape. Rogers misquoted1 the paper prepared by the Independent Second Opinion Panel 1987 which suggested "a joint examination between the police surgeon or other general practitioner and an experienced police surgeon may be the most 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 Jenny 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 the (null) 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.3

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.4-11 Bamford and Roberts12 when describing the signs of intercultural 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 unstriated hymenal orifice is no more than 0.5–0.6 cm increasing slightly as puberty approaches. The RCP Report13 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.14-16 These papers are descriptive of the signs associated with abuse in English children. Rogers and Roberts are anecdotal in this paper and consequently unconvinced 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.17

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 from the US) and practitioners need to use this to inform their practice.

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