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.¹ 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).² 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.³

Children should be seen and examined by children's doctors with appropriate training and good links with the local genitourinary medical 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 advice of a police surgeon is requested as indicated, for example a stranger rape. Rogers misquoted¹ the paper prepared by the Independent Second Opinion Panel 1987⁴ which suggested "a joint examination between a paediatricians or other childrens doctor and an experienced police surgeon may be the most appropriate arrangement". As more childrens' 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. West⁵ in his helpful paper described the physical signs associated with accidental genital injury and the differentiation from CSA. Bays and Jenny⁶ 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 (nil) effect of tampon use.⁷ 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.^{8,9}

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 intercrural 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 0.5–0.6 cm increasing slightly as puberty approaches. The RCP Report¹² 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.¹⁷

There is a great deal of debate in the UK amongst paediatricians about CSA, but 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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17 Hobbs CJ, Wynne JM. *HIV infection in Child Abuse and Neglect* 1993. Edinburgh: Churchill Livingstone.

Rogers and Roberts reply:

Our article is based on our own experience of examining large numbers of children, giving expert evidence in court in many parts of the country for the Crown Prosecution Service, defence solicitors and Local Authorities, seeing many case records and reports by other doctors and a very careful review of the world literature.

Between us, we have spent a considerable time with Professor John McCann (refs 36, 53) and Dr. Astrid Heger (refs 42, 46), both of whom visited the UK and held workshops in the Yorkshire area to which Drs Hobbs and Wynne were personally invited and chose not to attend, though other paediatricians did.

Their letter refers to seven of their own publications, several of which refer to the same group of patients, some of whom were diagnosed as having been sexually abused on criteria (such as the occurrence of anal dilatation in the presence of stool) which are not now generally accepted as being reliable.

One author has personal knowledge that many of these children have not been found by the courts to have been abused, and some have not even been placed on an "at risk" register.¹

For these reasons, papers by Hobbs and Wynne were not included in our extensive list of references.

Their response to our article illustrates only too clearly the problems in the UK which sadly do not assist the welfare of children and which appall our American and Australian colleagues.

There should be a national peer review forum open to all doctors working in the field who are prepared to learn from their mistakes and move forward in the interests of children.

It is hoped that such a forum will shortly be set up under the auspices of the Royal Society of Medicine.

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1 Frothingham TE, Barnett RAM, Hobbs CJ, Wynne JM. Child Sexual Abuse in Leeds, Before and After Cleveland. *Child Abuse Review* 1993;2:23–34.

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.^{1,2} Unlike an "opportunistic" service, setting up a designated family planning (FP) clinic can be difficult without adequate resources, in particular funding, as commented by Carlin *et al*. However, an alternate option may be the integration of the local FP service in the