Physical Signs

Consider CSA in **unexplained anogenital bleeding** where no sign of external trauma is seen.

Consider CSA in **anogenital warts** (evidence suggests approximately 30-60% of cases are sexually transmitted, regardless of age-group or maternal infection).

Consider CSA in all cases of **vaginal foreign-body** other than toilet tissue.

Consider CSA in all cases of suspected **genital herpes or other STI, or pregnancy.**

Ano-Genital injuries

Consider CSA in all **anogenital injury** without clear consistent history of accidental trauma.

Consider CSA in all **non-midline/multiple anal lacerations ("fissures") or tags**, unless suspected inflammatory bowel disease.

Consider CSA in all unexplained apparent ano-genital bleeding (exclude urinary origin, puberty, urethral prolapse, lichen sclerosis and friable labial fusion by external examination)

Child sexual abuse is more common than childhood epilepsy, cancers and congenital heart disease put together

- It is equally common as physical abuse.
- The average time from abuse to disclosure is **7 years**
- Contact-abuse affects at least 1 in 20 children
- Only 1 in 8 cases come to attention of authority over time

Coventry Safeguarding Children PARTNERSHIP

One Minute Guide

Child Sexual Abuse

For Paediatricians, Emergency Doctors, and other Health Staff

March 2022

- We **must** respond at the **same threshold as for other forms of abuse:** safeguarding does *not* require certainty to level of criminal justice system.
- If signs or concerns are present, multiagency strategy discussion should occur
- Do show **professional curiosity** and **seek voice of the child.** See them without carer where possible.

Allegations/disclosures: The child needs to feel safe. Retractions are common. May be ambiguous, and language will reflect child's understanding and developmental level

Behavioural signs of emotional distress: These are non-specific but may include somatisation, mutism, wetting, soiling, eating disorders including obesity, self harming, sexualised behaviour and sexually harmful behaviour to self or others.

Physical signs include: STIs, ano-genital warts, pregnancy, anogenital trauma (bruising, laceration, bleeding), vaginal discharge, vaginal foreign bodies, bruising to thighs or buttocks, suction bruises, perianal scars, hymenal defects (specialist examination)

Behavioural concerns

Consider CSA in anogenital conditions which does not respond to usual treatment advice (including **wetting, soiling, unexplained genital pain, and intractable constipation**)

Consider CSA in behavioural presentations including **medically unexplained symptoms, sexualised behaviour, mutism, self-harm and eating disorders**

Think family – do any **siblings** show emotional distress?

Ask the child is anything else is bothering them. Consider prompts: "one of the things we always have to consider when someone has this problem, is sexual abuse..."

Do consider behaviours in context of developmental age.

Take safeguarding advice. Use professionals or strategy meeting to bring information together.

Disclosures

Document what the child says verbatim.

Ask open questions ('can you tell me more about that?', 'who is that?') and document what you asked.

Don't promise confidentiality, but be transparent in explaining what you will do.

Do explain you need to talk to others to keep the child safe

POLY VICTIMISATION: Children who have experienced one form of abuse are more at risk of other forms. Children who experience physical abuse are 6 times more likely to be sexually abused

Consider Sexual Abuse in ALL cases of child maltreatment, and proactively ask about relevant signs/behaviours

Inspection of anus and **external** genitalia should be part of the child protection assessment of **all** children under 5 with suspected physical abuse

Older children should be asked if they have any genital issues, and offered examination as part of child protection medical assessment

Responding to concerns

If you are **concerned** about CSA, seek safeguarding advice

Put your concerns into effective "danger statements" and make a MASH referral (concern about possible sexual abuse = risk of significant harm)

'You don't have to be sure to share'. SARC examination is **child-friendly** and can be **therapeutic**

Strategy discussion should include **paediatrics AND SARC** representation

treat anogenital bleeding, bruising, ulceration, and suspected abuse within last 7 days as **urgent. Specialist examination should occur within 24 hours**.

SARC examination can never exclude CSA, as most examinations are normal, but where there are physical findings it informs action; **'If we dont look, we wont find'**

Examination in the SARC

It's not just about gathering trace evidence (DNA), but also looks for **physical injuries** with a magnifying colposcope (including healed injuries, which may be present **indefinitely -** its never too late to refer)

It also provides **reassurance -** children are almost never as physically damages as they perceive themselves to be; debunking myths may prevent secondary psychological difficulties

And provides **holistic health care** including STI screening, Hep B vaccination, pregnancy screening, crisis care, Independent Sexual Violence Advisors and counselling referrals.

Telephone: **0808 196 2340** - Hours: 24/7

Medical conditions to be aware of:

Straddle injury: should have clear event history; unilateral laceration, typically between labia. Suspicious if symmetrical, central or involves vestibule (area between labia)

Labial Fusion: may be friable and bleed if stretched. Typically, postior but may be mid-labial.

Vulvovaginitis: nonspecific inflammatory response to allergens and/or poor hygiene. Concern if recurrent, bloody discharge or not responsive to advice

Lichen Sclerosis: classic figure of 8 palour surrounding genitals and anus may be absent in early stages; may present with itch (mistaken for sexualised behaviour) or spontaneous haemorrhage (mistaken from trauma/bruising)

Threadworms: may infest prepubertal vagina and cause intense itch (mistaken for sexualised behaviour)

- Coventry Safeguarding Children Partnership
- **References and further reading**

- Allnock, D. and Miller, P. 2013. *No one noticed, no one heard: a study of disclosures of childhood abuse*. NSPCC: London.
- Brook. 2012. *Sexual Behaviours Traffic Light Tool. A Guide to Identifying Sexual Behaviours*. Available at: www.brook.org.uk (accessed 1st February 2019)
- Cutland M The role and scope of medical examinations when there are concerns about child sexual abuse: A scoping review. Centre of Expertise on Child Sexual Abuse, April 2019. Radford, L. et al. (2011) Child abuse and neglect in the UK today. London: NSPCC.
- Royal College of Paediatrics and Child (RCPCH). 2015. *The physical signs of child sexual abuse: an updated evidence based review and guidance for best practice*. 2nd Edn. RCPCH London
- Royal College of Paediatrics and Child (RCPCH). September 2015 *Service specification for the clinical evaluation of children and young people who may have been sexually abused*. RCPCH London.