Interactive session: Part 1
Genital examination when sexual abuse is suspected and normal genital exam findings. Why, Where, When, and How?

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Dr Andrea Smith, Paediatrician, VFPMS
Assessment after sexual assault

Historical allegations
- Assault occurred > 7 days prior to statement
- Often younger children
- Examination less likely to reveal findings, no indication for DNA collection
- Consider if medical assessment required

Recent allegations
- Within 7 days
- Often adolescents
- Forensic examination more likely to be indicated
- Consider all issues for young person
WHY? - the purpose of the acute SA examination

Medical
- STI/pregnancy prevention
- Acute injury management and reassurance

Psychological
- Gatehouse/SECASA
- Empathy with ‘victim’ and family
- Crisis mental health – suicide risk
- Ethical considerations

Protective
- Need for Child Protection

Criminal
- DNA/evidence collection connecting alleged perpetrator with crime
- Evaluate genital exam findings in forensic context

Acute sexual assault exam
WHEN? – timing of acute sexual assault examination

- To collect DNA that may link alleged perpetrator with crime
- To identify genital injuries – these may heal rapidly without scarring
- To address medical and psychological needs

Level of urgency is a balance between chances of gaining probative evidence and ethical/workforce considerations:

- Examinations conducted within 72 hours have increased yield – so the sooner, the better?
- Genital examination, swabs and DVD recording, co-operation & emotional well-being of patient
- Workforce issues
- “Just-in-case” examinations
2019 VFPMS guidelines

• No general consensus, variable guidelines.
WHERE? – best person, best place

• The hospital nearest the child’s home?
• Balance between convenience and skill/expertise
• Anxiety around court and legal implications create unwillingness?
• Consider equipment
  • “DNA-free” facility?
  • Colposcope and recording equipment?
  • Time constraints?

• Situation in Victoria
  • Metro vs regional
  • Levels of expertise – assessment & expert testimony
  • Travel, inconvenience
VFPMS sexual assault exams 2018

- Metro: 174,89%
- Regional: 21, 11%
The wrong place – the case of Mr Jama

AN INNOCENT man who served 15 months in jail after being wrongly convicted of rape based on a DNA bungle has spoken of his terrifying experience.

Speaking after the release of a scathing report on the handling of his case, Farah Jama, 22, said he wanted an apology from the government after he was jailed for “no reason”.

"Nobody will understand the pain I went through ... or the stress," Mr Jama said. "You kind of lose hope."

The conviction against Mr Jama was quashed last December, with the prosecutor admitting a "substantial miscarriage of justice" as the DNA evidence was contaminated.
How – logistics and techniques

- Call from Police (usually)
- Obtain information to decide on TIMING
- Check you have valid CONSENT
- Inform counsellor
- ATTEND
- Hx from Police/carer/CP and from patient
- Patient-led – chooses who attends apart from chaperone (‘observer’) compulsory
- Joint assessment with counsellor
- Examination
  - Chaperone
  - General physical and skin examination
  - Genital and anal examination
  - Forensic specimen collection – the FMEK
- Treatment, investigations
- TAKES TIME – don’t let yourself be rushed
Examination techniques

A) Supine frog-leg or butterfly position

B) Knee-chest position

Labial separation

Labial traction
Examination techniques 2

• Technique
  • Use of a speculum?

• Confirmation
  • Alternative position (prone-knee-chest)
  • Water in syringe – float hymen
  • Moistened cotton swab (post-pubertal)
  • (Foley catheter)

• Remember the hymen is sensitive in pre-pubertal children – swabs off!!
Was the child alone for the history and or physical examination?
Oral trauma? Exudative pharyngitis?
Tanner stage?
Injuries documented in context of position(s) and techniques used?
Description of hymen/penis and anus
Forensic swabs and material

- Dependent on **history** and examination (eg love bites/bite marks)
- Consider
  - DNA – saliva, skin cells “touch DNA”, semen
  - Sperm
  - Tampons, condom, toilet paper
  - Fingernails
  - Foreign material – hair, ejaculate in hair, vegetation, fibres
  - Clothing

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<thead>
<tr>
<th></th>
<th>Wet swab</th>
<th>Dry swab</th>
<th>Slide (sperm microscopy)</th>
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<td>Skin cells (touch DNA)</td>
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<td>Semen (genital)</td>
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Genital examination findings - what is normal?
A Normal  
B Imperforate  
C Microperforate  
D Cribiform  
E Septate
The sexual assault examination – case studies
Case study 1

- DSC Jo Bloggs calls you at 10pm
- 15 year old girl from Residential Care Unit, alleging penile-vaginal rape at 1am
- Was intoxicated with alcohol at the time, had smoked 2 bongs of marijuana
- Previous Hx of self-harm
- Male acquaintance, about 22 years old, of Black African appearance
- No condom, not sure about ejaculation
- Has not showered, Police have retained the clothes she was wearing

- What are the issues that need addressing?
Medical
STI risk
Pregnancy risk
Psychological
Self harm risk
Protective
High-risk behaviours
Criminal
Specimens to collect
Logistics
Consent
Timing
Medical
STI risk
Pregnancy risk
Case study 2

- Called by CP worker re 7 year old girl who stated to school teacher that step-father “put his doodle in my bottom”
- Police informed and VARE being done that day

- What do you do next?
- What information do you need?
- What issues do you need to consider?
- Are you going to do a forensic examination and if so, when?
- What do you think you might find?
Interactive session: Part 2:
Forensic significance of abnormal genital examination findings: An update in a rapidly changing field

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Abstract

Most sexually abused children will not have signs of genital or anal injury, especially when examined nonacutely. A recent study reported that only 2.2% (26 of 1160) of sexually abused girls examined nonacutely had diagnostic physical findings, whereas among those examined acutely, the prevalence of injuries was 21.4% (73 of 340). It is important for health care professionals who examine children who might have been sexually abused to be able to recognize and interpret any physical signs or laboratory results that might be found. In this review we summarize new data and recommendations concerning documentation of medical examinations, testing for sexually transmitted infections, interpretation of lesions caused by human papillomavirus and herpes simplex virus in children, and interpretation of physical examination findings. Updates to a table listing an approach to the interpretation of medical findings is presented, and reasons for changes are discussed.

Key Words: Child sexual abuse, Sexually transmitted diseases, Medical findings
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<td>• Normal variants</td>
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<td>• Findings caused by medical conditions</td>
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<td>• Conditions mistaken for abuse</td>
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<th>No expert consensus</th>
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<tr>
<td>• Anal dilatation</td>
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<td>• Notches/clefts</td>
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<td>• Genital/anal warts</td>
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<td>• HSV</td>
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<th>Trauma +/- or sexual contact</th>
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<td>• Findings indicating acute or healed trauma</td>
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<td>• Sexually transmitted infections</td>
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<td>• Pregnancy</td>
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<td>• Semen</td>
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What NOT to worry about

1. Normal variants
   - Annular vs crescentic
   - Congenital 1-3% - septate, microperforate, imperforate, redundant
   - Tags, bumps, mounds, intra-vaginal ridges
   - Smooth narrow posterior rim of hymen
   - Any notch or cleft **regardless of depth** above the 3 and 9 o’clock positions
   - **Superficial notch or cleft** at or below the 3 and 9 o’clock positions
   - Linear vestibularis, diastasis ani, perianal skin tags
   - Labial hyperpigmentation

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**Section 1. Physical findings**

A. Findings documented in newborns or commonly seen in nonabused children. These findings are normal and are unrelated to a child’s disclosure of sexual abuse

**Normal variants**

1. Normal variations in appearance of the hymen
   - a. Annular: hymenal tissue present all around the vaginal opening including at the 12 o’clock location
   - b. Crescentic hymen: hymenal tissue is absent at some point above the 3-9 o’clock locations
   - c. Imperforate hymen: hymen with no opening
   - d. Microperforate hymen: hymen with 1 or more small openings
   - e. Septate hymen: hymen with 1 or more septae across the opening
   - f. Redundant hymen: hymen with multiple flaps, folding over each other
   - g. Hymen with tag of tissue on the rim
   - h. Hymen with mounds or bumps on the rim at any location

   - Any notch or cleft of the hymen (regardless of depth) above the 3 and 9 o’clock location
   - A notch or cleft in the hymen, at or below the 3 o’clock or 9 o’clock location, that does not extend nearly to the base of the hymen

   - Smooth posterior rim of the hymen that appears to be relatively narrow along the entire rim; might give the appearance of an “enlarged” vaginal opening
Non-abused children

• Normal variants
• Medical conditions
• Mistaken for abuse

2. Findings commonly caused by conditions other than trauma or sexual contact

- Red vagina
- Labial adhesions
- Posterior fourchette friability
- Vaginal discharge
- Molluscum
- Anal ‘fissure’ /laceration
- Venous congestion perianal area
- Anal dilatation
  - Constipation
  - Sedation/anaesthesia
  - Neuromuscular disease
  - Post-mortem

B. Findings commonly caused by medical conditions other than trauma or sexual contact. These findings require that a differential diagnosis be considered, because each might have several different causes

12. Erythema of the anal or genital tissues
13. Increased vascularity of vestibule and hymen
14. Labial adhesion
15. Friability of the posterior fourchette
16. Vaginal discharge that is not associated with a sexually transmitted infection
17. Anal fissures
18. Venous congestion or venous pooling in the perianal area
19. Anal dilatation in children with predisposing conditions, such as current symptoms or history of constipation and/or encopresis, or children who are sedated, under anaesthesia, or with impaired neuromuscular tone for other reasons, such as postmortem
3. Conditions mistaken for abuse

- Urethral/rectal prolapse
- Lichen sclerosis
- Ulcers
- Infection (not STI)
- Peri-anal creases
- Post mortem changes

C. Findings due to other conditions, which can be mistaken for abuse

20. Urethral prolapse
21. Lichen sclerosus et atrophicus
22. Vulvar ulcer(s), such as aphthous ulcers or those seen in Behcet disease
23. Erythema, inflammation, and fissuring of the perianal or vulvar tissues due to infection with bacteria, fungus, viruses, parasites, or other infections that are not sexually transmitted
24. Rectal prolapse
25. Red/purple discoloration of the genital structures (including the hymen) from lividity postmortem, if confirmed by histological analysis
D. No expert consensus regarding degree of significance. These physical findings have been associated with a history of sexual abuse in some studies, but at present, there is no expert consensus as to how much weight they should be given, with respect to abuse.

Findings 27 and 28 should be confirmed using additional examination positions and/or techniques, to ensure they are not normal variants (findings 1.i, 1.j) or a finding of residual traumatic injury (finding 37).

26. Complete anal dilatation with relaxation of the internal as well as external anal sphincters, in the absence of other predisposing factors such as constipation, enopresis, sedation, anesthesia, and neuromuscular conditions

27. Notch or cleft in the hymen rim, at or below the 3 o'clock or 9 o'clock location, which extends nearly to the base of the hymen, but is not a complete transection. This is a very rare finding that should be interpreted with caution unless an acute injury was documented at the same location.

28. Complete cleft/suspected transection to the base of the hymen at the 3 or 9 o'clock location.
E. Findings caused by trauma. These findings are highly suggestive of abuse, even in the absence of a disclosure from the child, unless the child and/or caretaker provides a timely and plausible description of accidental anogenital straddle, crush or impalement injury, or past surgical interventions that are confirmed from review of medical records. Findings that might represent residual/healing injuries should be confirmed using additional examination positions and/or techniques.

1) Acute trauma to genital/anal tissues
29. Acute laceration(s) or bruising of labia, penis, scrotum, or perineum
30. Acute laceration of the posterior fourchette or vestibule, not involving the hymen
31. Bruising, petechiae, or abrasions on the hymen
32. Acute laceration of the hymen, of any depth; partial or complete
33. Vaginal laceration
34. Perianal laceration with exposure of tissues below the dermis
2) Residual (healing) injuries to genital/anal tissues
35. Perianal scar (a very rare finding that is difficult to diagnose unless an acute injury was previously documented at the same location)
36. Scar of posterior fourchette or fossa (a very rare finding that is difficult to diagnose unless an acute injury was previously documented at the same location)
37. Healed hymenal transection/complete hymen cleft—a defect in the hymen below the 3-9 o’clock location that extends to or through the base of the hymen, with no hymenal tissue discernible at that location
38. Signs of FGM or cutting, such as loss of part or all of the prepuce (clitoral hood), clitoris, labia minora or labia majora, or vertical linear scar adjacent to the clitoris (type 4 FGM)
Normal or abnormal?
Questions?

"And now Edgar's gone. ... Something's going on around here."