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Genital Examination of Young Girls

RACP Guideline

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Contents

1. Purpose of this Guideline

The purpose of this guideline is to guide medical practitioners and nurses in relation to the indications for, and the conduct of, genital examinations in girls and young women. Paediatricians, particularly those involved with child protection work, may be called on to perform genital examinations of girls and young women.

This guideline may be of interest to all health professionals who conduct genital examinations on girls and young women.

This guideline does not specifically refer to examination of the anal region. It should be noted, however, that examination of the perineum and anal region is usually appropriate when girls and young women are examined because of suspected genital inflammation, infection or assault.

2. Governing Principles

The following governing principles should be considered prior to conducting a genital examination on a girl or young woman:

- The girl's or young woman's **best interests** (their physical and psychological health and wellbeing) are paramount and should guide all decision making.
- Best practice in examining girls and young women revolves around effective **communication**. It is imperative that medical practitioners and nurses take the utmost care in explaining the procedure(s) to the girl or young woman (and her parent/guardian).
- The girl's or young woman's **dignity and privacy** should be maintained throughout the examination, regardless of the presence of others.
- The examinations of a girl's or young woman's genitalia should be conducted in a manner that **minimises discomfort and distress** for the patient. In particular, care should be afforded to avoid unnecessarily touching the hymen of prepubertal girls because this might cause pain or discomfort.

Medical professionals should be informed about and have familiarised themselves with any tests that need to be performed, the equipment required and methods of sampling for investigation prior to commencing the examination.

3. Adopting a cultural lens

Over the past decade, research and treatment literature in the field of child maltreatment has become more responsive to cultural issues and certainly more nuanced. Health professionals working with children from culturally and linguistically diverse groups often find themselves with the challenge of exploring and resolving the tension between definitions of harm in child protection practice and various cultural and child-rearing practices. Adopting a cultural lens means acknowledging the role of culture in the child or young person's life and contextualising it. For the individual practitioner, culturally competent clinical practice is about self-reflexive practice and not assumptions or generalisations.

Clinicians should be aware that girls and young women from certain ethno-cultural groups may not be comfortable discussing their genitalia or sexual acts and may not want male clinicians to examine them, or their parents may not allow it. Raman and Hodes provide a simple guide to culturally competent healthcare in their exploration of 'Cultural issues in child maltreatment'.[1] The Royal College of Paediatrics and Child Health in the excellent Child Protection Reader provides a well-developed section on 'Ethnicity and cultural perspectives in CAN'.[2] The RACP policy statements on cultural competent practice for indigenous Aboriginal and Torres Strait Islander and Maori peoples recognise that cultural competence must be integrated in the delivery of health services in order to reduce institutionalised racism.[3] [4]

4. Indications for a genital examination

Inspection of the genital area of girls and young women is commonly required as part of good medical practice. Indications include (but are not restricted to) the examination of newborn female babies, skin rashes in the genital area, urinary tract infection, enuresis, herniae and symptoms affecting the genital area.

A genital examination might be indicated in relation to suspected or alleged:

- Sexually transmissible infection
- Pregnancy
- Pelvic pain or other genital symptoms or concerns
- Sexual assault
- Foreign body

Cervical cytology screening is ***not*** currently recommended until the age of 25 years.[5]

The decision to perform a genital examination is the responsibility of the examining medical professional. This decision should be based on the:

- Appropriateness of medical indications (including forensic medical indications), and
- Willingness of girl or young woman and/or parent/guardian, and
- Circumstances of the presentation (time, pain etc).

5. Examiner/personnel

Medical professionals who perform genital examinations should be appropriately trained and experienced.

Trans-vaginal ultrasound scans, examinations under anaesthetic and evaluations for suspected sexual assault should only be performed by medical professionals who have satisfactorily completed relevant training or are under relevant clinical supervision.

In clinical practice, there may be requests from parents and/or child welfare agents to provide an examiner of the same gender as the young pre-pubertal child (up to 10 years of age). Parents can be reassured that in the context of suspected sexual abuse the limited literature available suggests that for children the behaviour of the doctor, such as showing kindness, is more important than gender.[6] However, where feasible, requests from the family or young woman in relation to the examining doctor should be respected.

An appropriate support person should be present when examining a girl or young women. Many girls and young women prefer the support of a trusted family member or close friend. The support person should be a person of the girl or young woman's choosing. Also, another professional may be present during the examination. Contemporary professional guidelines in relation to the role and responsibilities of chaperones should be considered.

With respect to examining a girl or young woman, the presence of a trusted family member or other support person should be the routine. However, the girl or young woman's right to decline their presence, and the doctor's right not to proceed with an examination without their presence, ought to be respected. This practice provides important support for both the girl or young woman and the doctor.

6. Consent

Medical professionals need to ensure valid consent is obtained prior to conducting a genital examination. This is from a parent/guardian on behalf of a child or from a young woman herself and/or their parent or guardian. Valid consent must be voluntary, informed and consider the capacity of the girl or young woman to consent.

Medical professionals should familiarise themselves with relevant state/territory legislation regarding capacity to consent. Capacity to consent should be considered on an individual basis and is not solely related to age. Children can consent as long as they have the capacity to understand the information and the implications of the procedure to which they are consenting. [7]

When parents or guardians have consented on a girl's behalf, medical professionals should take the utmost care in explaining the procedure(s) and proceed only with the girl or young woman's assent. Special consideration needs to be given to obtaining consent from patients who have or are:

- Living with an intellectual disability
- Experiencing mental health problems
- Living with Physical disability
- Drug or alcohol affected
- Culturally and linguistically diverse
- Injured, in pain or in shock
- Sleep deprived

- Unable to give valid consent

Except in a medical emergency, genital examination should not proceed in the absence of valid consent.

7. Confidentiality

Girls or young women who have the capacity to consent should be given the opportunity to talk privately with the medical professional. The medical professional should ensure that the girl or young woman understands that confidentiality cannot be guaranteed in the following circumstances:

- Risk of serious harm to self or others
- Suicidal ideation
- Serious criminal activity
- Psychosis
- Sexual or physical abuse

In situations when assurances regarding confidentiality cannot be given, the girl or young woman and their guardian should be informed regarding the potential release of information. Discussion should include information regarding the professional identity of individuals who might receive this information, details of how and when information will be shared and the range of uses to which it may be put.

8. Explanation of Findings to the Child and Parents

Care should be given to explaining the examination findings to the girl or young woman. Explanations need to be tailored to the girl's or young woman's level of comprehension and reassurance given where appropriate.

In circumstances when the parent or guardian is providing consent to the examination of a girl or young woman, or when the girl or young woman consents to the sharing of information, an explanation of the examination findings should be provided by the examining doctor during the consultation.

9. Factors that Influence the Conduct of Genital Examinations

9.1 Age

In babies and toddlers genital inspection is often an important aspect of the general medical examination. Digital or instrumental vaginal examination is very rarely indicated in pre-pubertal girls. Allegations of sexual abuse, vaginal bleeding, vaginal discharge or suspected genital malformation may require visual inspection of the vaginal vestibule and/or ultrasound examination. If this does not reveal the required information and further examination is deemed medically necessary, then examination under anaesthesia by appropriately trained medical professionals may be indicated.

In a pubescent or post-pubertal girl, digital or instrumental examinations of the genitalia should only be performed with the consent of their parent/guardian or in the case of a mature minor, their consent. There should always be an agreement with the girl or young woman to examine her genitalia (assent).

Privacy and confidentiality are of the utmost importance in dealing with girls and young women. Components of the examination and findings (normal and abnormal) must be communicated to the girl or young woman at her level of comprehension.

9.2 Prior Sexual Experience

Digital or instrumental vaginal examinations are unlikely to be indicated for a girl or young woman who states that she is NOT sexually active. If a visual inspection of the vaginal vestibule does not reveal the required information and further examination is deemed medically necessary, then an instrumental examination may be performed (with anaesthesia if necessary) by a trained and experienced medical professional.

Medical professionals should be aware that a significant proportion of young people under 16 years of age report having had sexual intercourse.[8] However, sexual experience does not automatically mean that an internal digital or instrumental vaginal examination is either necessary or acceptable to a young person.

Consideration should be given to the legal obligation of medical practitioners to report such behaviour. The possibility that the sexual intercourse was non-consensual and occurred in the context of child sexual abuse or assault should also be considered.

9.3 Suspected or Alleged Sexual Assault

When sexual assault is suspected (history from the girl or young woman, family/friends, police or clinically) a genital examination may be indicated and should be conducted by a medical professional with specific training. Medical professionals performing examinations for suspected sexual abuse must act in accordance with regional policies, procedures and practices and in accordance with local government legislation.

Unless there is a medical emergency, best practice principles indicate that the girl or young woman should have a single examination.

Medical care should be provided in a holistic manner that addresses the girl's or young woman's psychological needs and provides for her continuing health and wellbeing. In many centres this care is provided by a multidisciplinary team.

When sexual assault is alleged to have occurred recently, the girl or young woman should be offered a comprehensive forensic medical evaluation, including a genital examination. An urgent forensic medical examination might be considered when alleged genital contact occurred at any time within the previous 72 hours. Depending on the nature of the alleged genital contact, this time-frame for an urgent examination might be shortened to 24 hours or extended to 5 to 7 days.

When sexual assault is alleged to have occurred outside this timeframe, the girl or young woman should be offered an appointment for a medical evaluation to assess her general health and wellbeing. A genital examination may form part of that assessment.

Photo-documentation of genital examination findings is regarded as 'best practice.'[9] Video-colposcopic documentation is regarded as superior to still photography. Consent for photo-documentation should be obtained prior to the procedure. Adequate security for the photo-documents must be ensured and maintained.

Photo-documentation might be viewed by suitably qualified medical professionals in order to provide a second opinion about examination findings. However, photo-documentation should not be released for viewing by members of the public (including jurors and legal professionals).

Opinions provided regarding the forensic significance of genital examination findings should be in accordance with the latest evidence-base and consensus opinion published by colleges of medical experts working in the field of child and adolescent sexual assault.[10,11,12] Terminology and descriptions of genital examination findings should be in accordance with these guidelines.

10. Vaginal instrumentation and medication

Instrumental vaginal examinations are unlikely to be indicated for a young woman who states that she is NOT sexually active.

10.1 Speculum Examination

The indications for speculum examination include:

- Endocervical swab for investigation of possible infection, when symptoms are present
- Endocervical swab for forensic investigation
- Assessment for abnormal per vaginal bleeding
- Assessment for possible intra-vaginal foreign body.

10.2 Examination Under Anaesthetic

Examination under anaesthesia (EUA) is rarely indicated and should only be undertaken when information being sought cannot be obtained by examination of the conscious girl or young woman or surgical intervention is required and valid consent has been obtained. For example, when the extent of a significant genital injury that might require surgical repair cannot be elucidated through a "standard examination".

An EUA should not be undertaken solely for swab collection (either microbiological and/or forensic).

If the doctor experiences difficulty with a genital examination, clinical consultation should be sought from appropriate tertiary level specialists (forensic physicians or paediatricians, or paediatric gynaecologists) on alternative methods for collection and treatment, appropriate for the particular clinical scenario.

When EUA is indicated medical professionals must ensure that adequate equipment appropriate for the size/age of the girl or young woman is available. This might include a nasal speculum (for use in the vagina), hysteroscope (for use in the vagina), narrow speculum (rather than the usual adult size)

and adequate lighting. Medical professionals undertaking the EUA should have adequate knowledge to allow recognition and interpretation of the findings/pathology in girls and young women.

10.3 Per Vaginal medications

The use of vaginal pessaries in prepubertal or adolescent girls as a means of administering medications is not appropriate.

10.4 Trans-vaginal ultrasound scan

Trans-vaginal ultrasound is a non-ionizing radiologic investigation that is used in conjunction with trans-abdominal imaging to obtain more accurate visualisation of the pelvic organs. Whilst the indications for this examination are limited in this age group, it may be appropriate for use in some young women where clinically indicated.

Trans-vaginal ultrasound scans must only be performed with the patient's (parent/guardian's) informed consent. Consideration should be given to the presence of a support person and/or chaperone.

Guidelines for the performance of such an examination and gynaecologic examinations are provided in the Australian Society for Ultrasound Medicine (ASUM)policy manual with specific reference to ASUM Policy C3, Policy on Vaginal Scanning by Sonographers and Policy D8, Guidelines For Performance of a Gynaecologic Scan.[13,14]

11. Changes to Appearance of Genitalia during examination

Occasionally the examination of a girl or young woman's genital area may result in changes to the genitalia. For example, separation of the labia may bring about dehiscence of labial adhesions.

Any alteration to the appearance of genitalia that occurs as a result of examination should be documented and the girl or young woman and her parents/guardians informed.

Appendix: Suspected Sexually Transmissible Infections

A. 1 Investigations for STI pre and post puberty

The anatomy, physiology and normal flora of the prepubertal genitalia, particularly the vagina, differs from post pubertal genitalia.

Non-specific vulvovaginitis is the commonest cause of genital discomfort and or a vaginal discharge in a prepubertal child. The vaginal discharge is usually watery and often associated with an oval area of erythema (inflammation) around the labia majora. Swabbing is not indicated as part of initial management and may cause unnecessary discomfort to the child.

Any results should be interpreted with an understanding of the normal flora seen in the vagina in this age-group. Microbiological screening should be considered if the discharge is purulent, if the girl has a vaginal discharge and appears systemically unwell or if usual measures to resolve the symptoms have failed and the reported amount of discharge remains significant.

In post pubertal girls/young women, consideration should be given to tests for sexually transmissible infections that affect adult women. These infections include, but are not limited to: : Chlamydia trachomatis, Mycoplasma genitalium, Neisseria gonorrhoea, Trichomonas vaginalis, herpes simplex virus (HSV). Vaginal infections associated with sexual activity but not necessarily transmitted include bacterial vaginosis, Candida albicans.[15, 16]

Testing for STI should be evidence-based and according to latest recommendations.[17, 18, 19] The medical practitioner should check the latest guidelines. The choice of samples and tests will also depend on the following:

- age of the child/young person,
- nature of the sexual contact
- presence of genital injury
- pre-existing STI
- whether sexual contact was consensual and/or non-consensual,
- age of sexual partners,
- sexual risk group of sexual partners (eg HIV prevalence)
- the girl's or young woman's symptoms and signs
- the prevalence of STIs in the local population

It is currently recommended that annual asymptomatic screening for chlamydia is undertaken in in sexually active young people of both sexes between ages of 15-29 years.[20] Self-collected samples (first past urine or high vaginal swab) should be considered when appropriate.[21] HPV testing is not currently recommended until age 25 years under the new cervical screening guidelines.[22]

All results must be followed up by medical professionals. Results must be provided to the girl or young woman and parents/guardians as appropriate.

Treatment should be provided according to the latest recommendations.[23]

Notification to the Department of Health or alternative authority should occur for notifiable diseases in accordance with local legislation.

Contact tracing should occur regardless of the age of the child and circumstances under which sexual contact occurred.

A. 2 Suspected STI following sexual assault

In circumstances of sexual assault, medical professionals should note the time interval between the initial assault and the examination to determine whether this falls within the window period for detection of sexually transmitted pathogens such as Chlamydia Trachomatis, Neisseria Gonorrhoeae

and Trichomonas Vaginalis. If the initial exposure was within a few hours or days of the examination, testing may need to be deferred or repeated.

When girls or young women are examined following recent sexual assault (defined as within the last 72 hours) the use of prophylactic antibiotics (e.g. Azithromycin 1g stat) should be considered depending on the nature of the alleged assault.

The use of post exposure prophylaxis for HIV, while rarely required, should also be considered in accordance with local guidelines.

Concerns have been raised about the specificity of testing techniques for Chlamydia and Gonorrhoea, other than culture. While culture of the organism is 100% specific, sensitivity is lower. Specificity of Nucleic Acid Amplification Test (NAAT) is high and is a more sensitive test, and therefore has a lower risk of missing the diagnosis of these infections.

For medico-legal purposes, consideration should be given to confirming, by culture, a positive NAAT result for Gonorrhoea unless treatment has already intervened. Alternatively, a NAAT which uses a different gene sequence could be used for further confirmation when swabs are taken from a girl's or young woman's genital tract.

Consideration should be given to documenting the chain of custody when results might be used for forensic and legal purposes.

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