Correspondence

Recognition and reporting of sexual abuse

Sir,

There will be much concern about the memorandum on child abuse central register systems issued by the Department of Health and Social Security (LASSL (84) 1980). The subject likely to provoke most discussion is that severe emotional abuse should be included among the conditions to be registered. We were disappointed that despite recommendations that sexual abuse of children should be placed under the definition of child abuse and be dealt with under the same procedures, the DHSS did not list it as a separate category. We think that this reluctance to take a strong, clear line on the handling of child sexual abuse will merely make worse the existing confusion among professions, and lead to further lack of activity. Area review committees disagree about whether a child who has experienced attempted or actual sexual intercourse, or other inappropriate genital contact with an adult, should be placed on a child abuse register,¹ and whether the procedures applicable to physical abuse should be applied also to sexual abuse. Few sexually-abused children have been placed on such a register.

We are concerned that there is no clear policy or procedure for handling cases of sexual abuse in the UK. Practitioners say they are bewildered by the problems of case management, quite apart from uncertainty about how to offer treatment. Our current level of knowledge and understanding of sexual abuse is equal to that pertaining to physical abuse in the late 1960s. There is much denial and emotional revulsion, and statistics of incidence are difficult to obtain; we suspect that there is gross underdiagnosis. In the USA figures of 1.3 per 1000 children are now being quoted, and our own incidence was at least 1 per 6000 children a year.¹ In addition, punitive attitudes prevail which deter professionals from recognising cases since police involvement and prosecution for incest or indecent assault are likely, and neither perpetrators nor victims come forward for help. Disintegration rather than rehabilitation of the family unit is likely because the father is sent to jail or the child victim placed outside the family, often resulting in double victimisation of the child.

It is disappointing that the DHSS decided not to give child sexual abuse a separate category as no mechanism exists for collecting data, apart from criminal statistics which are misleading. It has been argued that it is difficult to define child sexual abuse but we feel it is possible to provide a satisfactory operational definition and typology thanks to the pioneering work of American colleagues—such as Henry Kempe² and the Giarrettos.³

We believe that registration and the application of child abuse procedures would be a step towards better

management and the establishment of treatment programmes.

References

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Prostaglandins in salmonella-induced secretory diarrhoea

Sir,

Prostaglandins produce secretion of fluid and electrolytes in the intestine, via activation of the adenylyl cyclase-cyclic AMP mechanism.¹ The adenylyl-cyclase-cyclic AMP mechanism also accounts for the secretory diarrhoea which occurs during experimental salmonella gastroenteritis.² On the basis of animal experimental studies using prostaglandin synthetase inhibitors, it has been inferred that prostaglandins might be involved in the activation of adenylyl cyclase by salmonella organisms;² however, this hypothesis remains unsubstantiated.³

We are currently studying plasma prostaglandin levels in childhood diarrhoeal disorders. A 16-month-old girl, in hospital in our department because of failure to thrive, had a plasma level of 13-14-dehydro-15-keto-PG F_{2α} of 4 pg/ml (laboratory upper limits in adults—40 pg/ml), while her bowel motions were normal. Two days later, she fortuitously developed a profuse, secretory-type diarrhoea of sudden onset (up to 16 watery bowel motions a day with high electrolyte content); *Salmonella* sp. group B was subsequently isolated from stool cultures. During this episode, a repeat estimation of the plasma PG F_{2α} metabolite showed a level of 45 pg/ml, a more than 10-fold increase compared with the prediarrhoeal state.

Our demonstration of the acute rise in prostaglandin accompanying this diarrhoea, lends clinical support to