Controversy follow up

Sexual abuse—the final word?

When differing views are strongly held there is inevitably a tendency to confuse the facts underlying an opinion with the emotional issues that surround the controversy. While tabloid and television journalism thrives on exploiting this confusion it is the responsibility of a scientific journal to portray the underlying facts of an argument as far as possible and to let readers judge for themselves the merits of each of the opinions expressed. Highlighting controversial issues in the journal and allowing experts with differing opinions to explain their views is one way of strengthening the scientific basis of paediatrics.

Contributions to the Controversy section are normally accepted on the basis that a commentary will be commissioned and seen by the original author who will be invited to provide a 'summing up' argument. However, in the circumstances surrounding this particular controversy Dr Roberts provided her commentary on the basis that it would not be followed by a further contribution by Drs Hobbs and Wynne, who would nonetheless have the correspondence column available to them if they wished to reply. We showed Drs Hobbs and Wynne the commentary to allow them priority through the correspondence column of a forthcoming issue. In the event their response came so quickly it was inadvertently included immediately after Dr Roberts commentary.

Published articles, like intravenous injections, cannot be withdrawn. We have therefore invited Dr Roberts to provide a further comment which is published below.

EDITORS

Dr Roberts writes—

I believe that buggery is *not* a 'common, under-diagnosed form of child abuse.' Dr Arnon Bentovim, in his evidence to the Cleveland Child Abuse Inquiry, gave a figure of 1–2% anal dilatation in his cases. Patients with psychosexual problems related to child sexual abuse do not describe anal abuse in most cases (Dr May Duddle, personal communication). There is an astonishing difference between the figures of the Manchester women police surgeons and those of Wynne and Hobbs which requires explanation. The character of the two large northern

cities is similar but the Manchester figures are of children seen mainly at the request of the police and where there is usually a complaint from the child. Though in 60% to 70% of them no medical evidence can be found, they are probably mostly genuine cases of sexual abuse. We have found anal signs of buggery in only 3.3% of 879 children seen in the past two years, 37% of whom were under the age of 5 and all of whom were carefully examined from top to toe. In these cases there is a very much smaller proportion of children suffering physical abuse and neglect, though many of them are rather poorly parented. In contrast, the Leeds figures include many more children where physical abuse and neglect are present and I believe that in many of these cases spurious and false signs, which have been wrongly held to indicate sexual abuse, particularly anal abuse, have been found.

Perhaps it has been thought that it does not matter too much if another problem is added to the list in these poor and deprived children, though for the individual families suspected of sexual abuse as well as physical abuse, it does. But when these erroneous thoughts are then extrapolated to the general population and used to make a diagnosis of sexual abuse in children referred to outpatients for instance, it becomes a matter for concern. It does not aid the cause of the many sexually abused children in our society who desperately need our help for doctors to make the diagnosis on emotional and unscientific grounds.

Anal dilatation is an odd and intriguing phenomenon for which there is no satisfactory explanation. It has many similarities to yawning, which occurs for a number of reasons that are ill understood, at the opposite end of the alimentary tract. If it is a learned response to pain or discomfort, one must question why people with anal fissure do not learn it and why it is so variable and is extinguished so quickly. It may well occur more readily in the anus of the child than the adult and a number of factors which cause irritation of the anal area may perhaps cause the anus to become hypersensitive and to react in this way. It has been described in many forensic texts, and usually occurs in adult sodomites, and paediatricians quite rightly advise caution in the extrapolation of adult findings to children. An interesting point, however, is that though many adult women who have been subjected

to buggery as part of a rape or repeated buggery in a previous relationship are examined by the Manchester women police surgeons, anal dilatation has not been observed in such cases, though it has been seen rarely a few days after buggery has occurred in boys and girls.

Very much more work must be done to understand the normal and abnormal anus of the child, and in the meantime the greatest caution must be observed in making a diagnosis of anal abuse without a clear and unprompted history from the child.