CONTROVERSY—REVIEW OF A REPORT

Physical signs of sexual abuse in children

Physical Signs of Sexual Abuse in Children. A Report of the Royal College of Physicians. (Pp 72; £10 paperback.) The Royal College of Physicians of London, 1991. ISBN 1–873240–20–1.

This report comes from a working party set up by the Royal College of Physicians in December 1988, partly in response to the inquiry into child abuse in Cleveland 1987. The college was also concerned over major disagreements between branches of the profession regarding the significance of anogenital signs and the difficulties that were occurring in legal proceedings because of the divergence of views of some medical experts. In relation to this it is worthy of note that neither the British legal nor medical systems impose conditions or criteria on those doctors who set themselves up as medicolegal experts.

The introduction to the book tells us that the members of the working party were invited from all branches of the profession who might reasonably have and interest in the subject. They are not, however, all individuals who will be regularly dealing with cases of child sexual abuse. Those called to give evidence undoubtedly expressed some divergent views and it cannot have been easy for the working party to reach some of their conclusions. It was tempting when reading the report to speculate as to whose evidence was preferred on certain issues.

The terms of reference of the working party were to 'agree terminology, to describe the range of normal findings, to advise on techniques of examination, to produce evidence of what are the physical signs of child sexual abuse, to assess the significance of these in the light of existing knowledge and to produce suitable guidelines for the medical and legal professions and others concerned with sexually abused children'. The report might well have been improved by the inclusion of a legal brain particularly given the frequency with which we are now seeing this book appear in court rooms throughout the country. Indeed, this review was delayed while I retrieved my copy from the Crown Prosecution Service!

Early in the report the authors stressed the need for a consistent vocabulary and promised recommendations for terminology in appendix I. What emerges is disappointing with a glossary of terms for anal abuse only. Furthermore, there are discrepancies between the apparent definitions used in the text and those in the glossary. For example discrepancy in relation to anal fissures makes it difficult to follow the authors' reasoning over the causation and significance of fissures. In the text funnelling is seen as supportive of chronic abuse but in the glossary doubt is expressed over whether the condition exists! It is to be hoped that this portion of the report will be rewritten and a glossary also produced for genital signs.

In the chapter on medical evaluation and technique the working party advocates that a small number of doctors in each district should develop a high skill and experience in dealing with child sexual abuse. While supporting this view there is a need for all those seeing children to know something of the possible ways in which child sexual abuse can present and to be prepared when appropriate to consider it in the differential diagnosis. For example, I was concerned to see that in a recent annotation in this journal on the investigation of rectal bleeding the possibility of child sexual abuse was never mentioned,[1] yet children who have been anally abused often have one or more incidences of bleeding in their history.

I was pleased to see the working party endorsing the view that when a child is brought to see a doctor there is implied consent for any necessary examination.

The committee discourage the use of the prone knee/chest position for examination of the genitalia because of limited experience, seemingly contradicting their view that we need to increase our expertise. I also found myself disagreeing with the reason glass rods were not generally recommended. The working party felt that they should not be used to assess hymenal size because of the dynamic and elastic nature of the hymen. However, one major advantage I have found is that the rods allow demonstration of the potential size of the hymenal opening thereby giving valuable information on the possibility of penetration. In discussing the colposcope, the camera does get a mention; however, the use of photography and methods of recording findings are not discussed in any detail.

It took me sometime to understand why at times I was finding it difficult to follow the committee's reasoning. On a number of occasions they refer to the results in published studies and then pass to their opinion, which the reader is expected to take on trust without knowing the additional evidence upon which their definitive statement is based. Thus a reference to a study in which 22% of girls with a history of penetration (perpetrators' admissions) had no specific signs is followed by the statement that *rarely* findings may be absent even in young girls where both victim and assailant describe penetration. There are several other examples of

seemingly non-sequiturs to be found in the report.

A number of papers much quoted in legal proceedings do not get mentioned in the report. An example of this is the paper by Emans *et al* which is often used to support a non-abusive aetiology for attenuation of the hymen.[2] This I do consider deserved further consideration especially as attenuation of the hymen with loss of hymenal tissue is considered by the working party to be diagnostic of penetration trauma by blunt force. When considering foreign bodies the report introduces us to the idea that it is not unusual for a girl to introduce little pieces of toilet paper in to her vagina. This does leave those of us who have never seen a case with a problem!

The longest chapter in the book tackles anal abuse and contains one of the most useful sections of the report which puts the much quoted paper by McCann *et al* into context.[3] As I have indicated above I was left confused by the discussion on fissures in this chapter. Also the report does not tell us how to know the difference between a scar from a healed fissure and the scar of a healed laceration, which it considers to be diagnostic of penetrating trauma. The report appears to rehabilitate reflex anal dilatation as a respectable sign, which if it is greater than 2 cm in the absence of alternative explanations, is more likley than not to be associated with abuse.

Forensic evidence is dealt with in the main body of the report with further useful guidelines in one of the appendixes. Sexually transmitted diseases are dealt with in another appendix but do not include references to the standard venereology textbooks, which still maintain that gonorrhoea can be non-sexually transmitted in children.

The report is a gallant attempt to fulfil ambitious terms of reference but it is not the definitive statement on physical signs that many hoped it would be. There are too many inconsistencies leaving it open to selective quoting in the support of differing points of view. One of the problems may be that the group tried to consider issues in greater depth than did the Committee on Child Abuse and Neglect of the American Academy of Pediatrics.[4] This report should be read for comparison.

It is to be hoped that this report will lead to further discussions and a commitment to reach a consensus on the significance of many physical signs. The manner in which many child protection proceedings are currently vigorously contested is seldom in the best interest of the child and is dreaded by most paediatricians. However, it must be acknowledged that a minority of the medical profession are now dependent on second opinion legal work either as a main source of income or as a way of paying for school fees or skiing holidays.

Furthermore, shortage of resources within health and social services will make it increasingly difficult to undertake rapid and thorough multidisciplinary investigations in cases of suspected child sexual abuse, putting pressure on doctors to provide proof that abuse has or has not occurred. This report can be used to show very clearly that rarely can the doctor be expected to make the diagnosis of child sexual abuse alone.

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1 Raine PAM. Investigation of rectal bleeding. *Arch Dis Child* 1991;**66**:279–80.
2 Emans SJ, Woods ER, Flagg NT, Freeman A. Genital findings in sexually abused, symptomatic and asymptomatic girls. *Pediatrics* 1987;**79**:778–85.
3 McCann J, Voris J, Simon M, Wells R. Perianal findings in prepubertal children selected for non-abuse. *Child Abuse Negl* 1989;**13**:179–93.
4 American Academy of Pediatrics. Guidelines for the evaluation of sexual abuse of children. *Pediatrics* 1991;**87**:254–60.