Recognizing, Reporting, and Responding to Child Sexual Abuse in Kentucky
An Update for 2025

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Objectives

- Discuss how to care for the child who reports experiencing sexual abuse
- Recognize common presentations of child sexual abuse
- Apply critical thinking strategies when caring for adolescent and pediatric sexual abuse victims in public health

Case

- Mom receives a call from her 9 year old daughter's father. He confessed to her that he has been touching their daughter inappropriately.
- Mom asks her daughter, and her daughter discloses that she has experienced penile vaginal penetration on more than one occasion by her father.
- She brings the child to the clinic.
- Mom says that child never told her about the abuse previously and she saw no signs to indicate that the child was abused.
- The last incident was a little more than one week ago.

Presentations for Child Sexual Abuse

- Disclosure (intentional or unintentional)
- Concerning Signs and Symptoms (suicidal ideation, anxiety)
- Sexually Transmitted Infections
- Injury
- Pregnancy (less common)

After making sure a mandatory report of child sexual abuse is submitted, what do you do next?

Determining When And Where Children Who Report Experiencing Abuse Are Evaluated

- Nonurgent
- Urgent
- Emergent (within 72-96 hours)

Questions To Ask

- Is urgent or emergent medical attention needed?
  - Is the child having symptoms that need to be addressed urgently or emergently? (Severe pain, bleeding, dysuria, discharge?)
  - Is the child reporting suicidal ideation?
- Is the last reported incident of abuse within the recommended timeframe for the collection of potential biologic or trace evidence?
  - KY Law says 96 hours
- Is the last reported incident of abuse within the recommended timeframe for provision of
  - Emergency contraception (up to 120 hours)
  - HIV nPEP (up to 72 hours)
  - STI prophylaxis
- Is the child safe leaving the office with the accompanying caregiver?

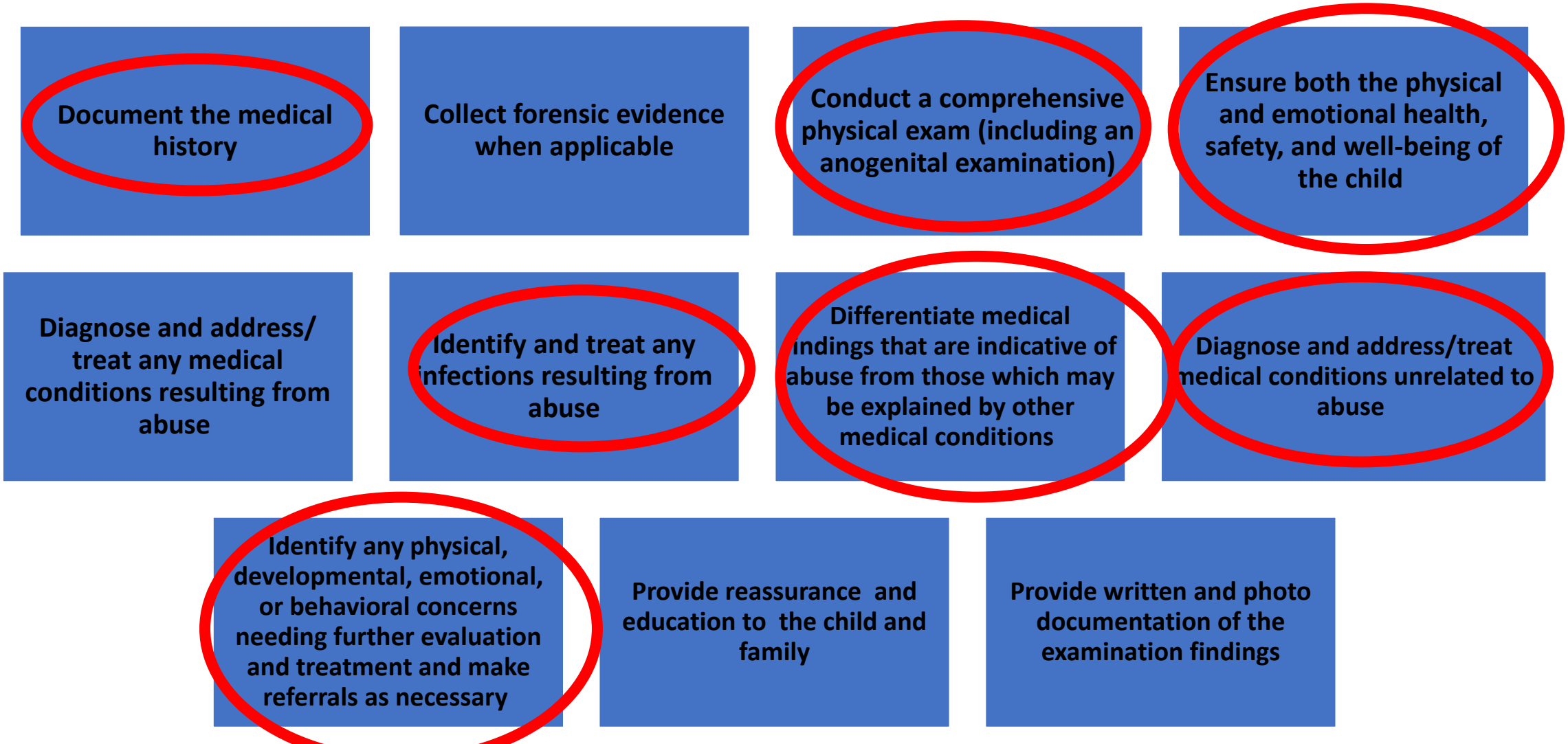
Non urgent exam (Can be scheduled by DCBS or law enforcement at a Children's Advocacy Center)

- Abuse occurred in a remote timeframe
- Child is not experiencing any symptoms (bleeding, dysuria, anogenital pain, discharge, SI)
- Child is in a safe environment

Urgent exam

- Reported sexual contact occurred within the previous 2 weeks, without emergency medical, psychological or safety needs identified

Purpose of the Medical Examination



Take a Medical History

- Take a medical history separate from caregiver. (Try to get as much information as you can from investigators and caregiver).
- If you have a detailed history from the caregiver or other source, you may not need to ask the child many questions.
- Ask open ended questions.
  - Why did you come to the clinic today?
  - Has something happened to your body that you didn't like or didn't understand? Can you tell me what happened?
- Avoid leading questions
- Document exact wording: what you asked the child and what the child said.
- Avoid documentation that uses words that have negative connotations.
  - Patient "reports," rather than patient "alleges"

How might you take a history from the caregiver and child in this case?

How might you take a history from a teen in the case of sexual abuse/assault?

Obtain Review of Symptoms

- Behavioral symptoms
- Physical symptoms

Physical Symptoms That May Be Related to Sexual Abuse

- Stress induced headaches or stomachaches
- Pain in the anogenital area
- Anogenital bleeding
- Genital discharge
- Anogenital injury
- Dysuria/urinary tract infections
- Constipation/encopresis (incontinence of stool)
- Enuresis (incontinence of urine; day or nighttime)
- Pregnancy
- None

Behavioral Symptoms That May Be Associated with Sexual Abuse

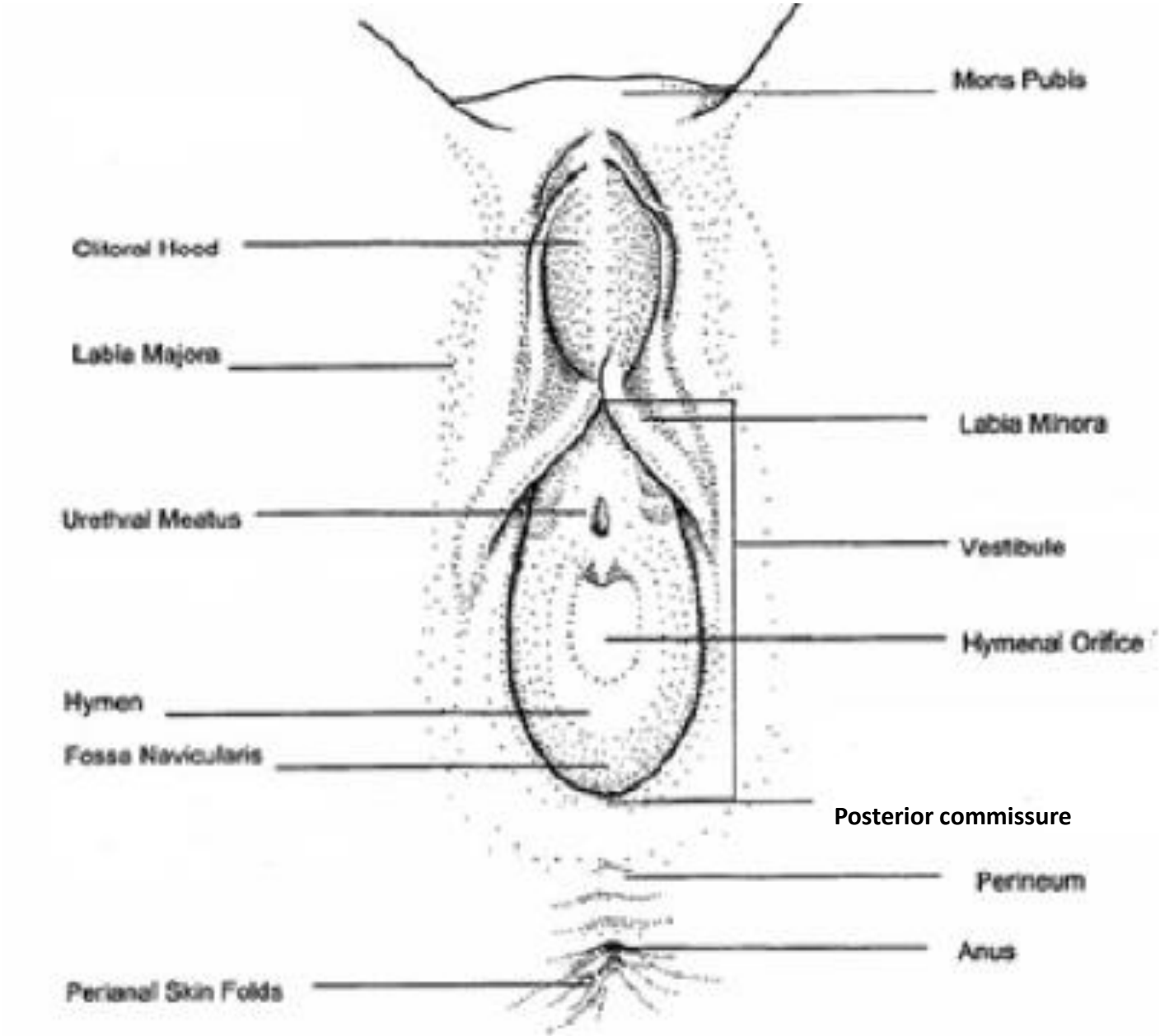
- Difficulty sleeping
- Change in eating habits
- Change in school functioning
- Change in interactions with family
- Anger
- Running away
- Suicidal ideation +/- attempt
- Problematic sexual behaviors
- None

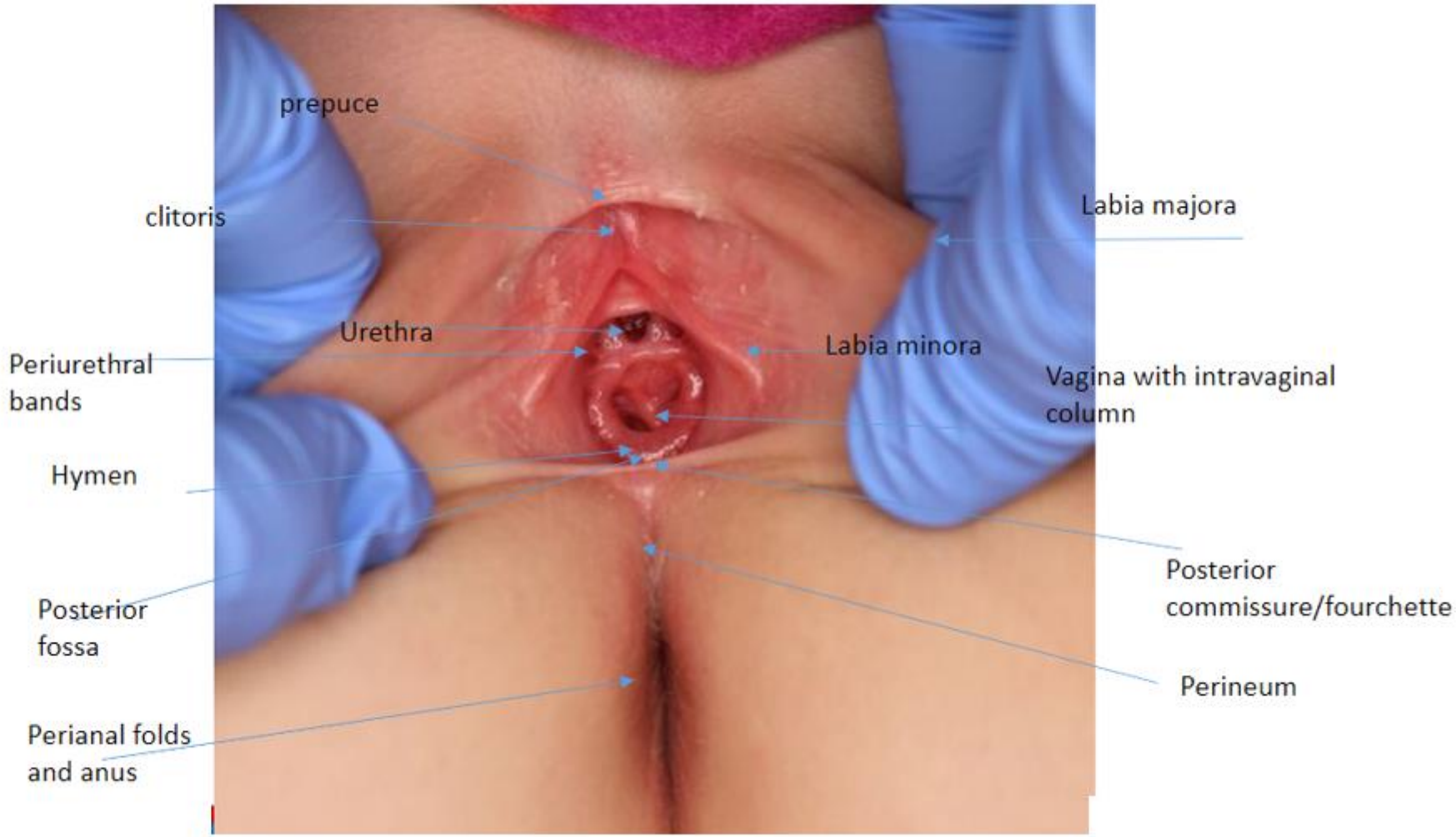
Questions You Might Consider Asking

- Sometimes kids come to see me because something has happened to their body that they didn't like, or didn't understand. Has anything like that happened to you?
- If something happens to your body that you don't like or don't understand do you know what to do? Is there a safe person that you can talk to?

Physical Examination

- Perform the exam with a caretaker or support person present if the patient desires one.
- Examiner **should have** a nurse or tech present to both assist and chaperone.
- Complete a head to toe exam.
- Examine for and document any injuries (not only genital injuries).
- Examine and determine sexual maturity.


Mons Pubis
Clitoral Hood
Labia Majora
Labia Minora
Urethral Meatus
Vestibule
Hymenal Orifice
Hymen
Fossa Navicularis
Posterior commissure
Perineum
Anus
Perianal Skin Folds


prepuce
clitoris
Labia majora
Urethra
Labia minora
Periurethral bands
Vagina with intravaginal column
Hymen
Posterior commissure/fourchette
Posterior fossa
Perineum
Perianal folds and anus

Labial separation

Labial separation and traction

Labial separation and traction

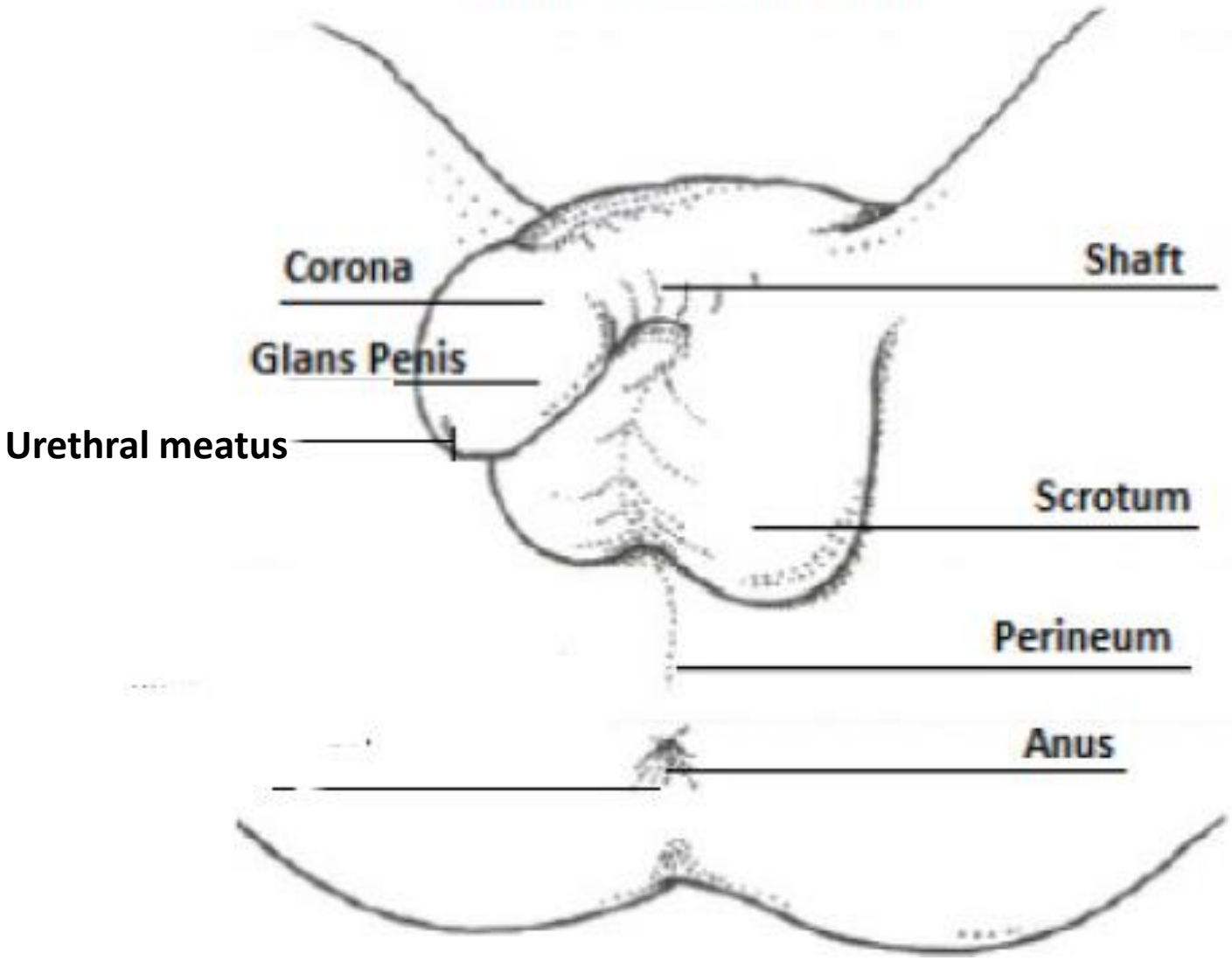
Estrogenized vs. Non-estrogenized Hymen

Estrogenized	**Non-estrogenized**

Types of normal hymens

How Do We Know What Normal Is?

Male Dorsal View



Medical Findings in Child Sexual Abuse

- Medical exam is normal.
- How do you explain that?

Medical Findings in Child Sexual Abuse: The majority of all children and adolescents who report sexual assault/abuse have normal examinations.

- **The nature of the assault/abuse may not leave injury.**
- **Disclosures of sexual assault/abuse are often delayed and peer reviewed medical literature supports that injuries typically heal rapidly, and sometimes without findings of residual healed trauma.**
- **There may be discordance between what a child perceives has happened and the actual event.**
  - **A child perceiving anal penetration or something touching the inside of the anal area, may be experiencing a penis or object rubbing between the gluteal clefts (the cheeks of the buttocks).**
  - **A child perceiving vaginal penetration may be experiencing rubbing of the penis between the labia or in the vaginal vestibule in front of the hymen.**
- **Medical literature supports that exams are normal even in cases where assailants have confessed to sexual assault/abuse.**
- **Children depicted in child sexual abuse material (CSAM) have had normal examinations.**
- **Children with sexually transmitted infections can have normal examinations.**
- **Even pregnant teens have been observed to sometimes have normal genital exams.**

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Normal Does Not Mean That Nothing Happened

- Acute definitive evidence that heals completely (McCann et al., 2007)
- Pregnancy (Kellogg, Menard, & Santos, 2004)
- Confirmed presence of an STI (Girardet et al., 2009; Kellogg et al., 2018)
- Confirmed presence of foreign DNA (Girardet et al., 2011; Thackeray, Hornor, Benzinger, & Scribano, 2011)
- Photographic evidence of sexual abuse (Vrolijk-Bosschaart et al., 2017)

Acute Hymenal Lacerations

Hymenal Contusion

Acute and Healed Hymenal Transections

Acute Hymenal Transection

What Lab Testing Could You Obtain?

Factors that should lead the medical provider to consider testing for STIs

- Penetration: Child reports or there is evidence of recent or healed penetrative injury to the genitals, anus, or oropharynx.
- Perpetrator
  - is a stranger.
  - an assailant with high risk of infection: known to be infected with an STI or at high risk for STIs (e.g., injecting drug user, MSM, person with multiple sex partners, or person with a history of STIs).
- People: the child has a sibling, other relative, or another person in the household with an STI.
- The child lives in an area with a high rate of STIs in the community.
- The child has signs or symptoms of STIs (e.g., vaginal discharge or pain, genital itching or odor, urinary symptoms, or genital lesions or ulcers).
- Parent or child requests STI testing.
- The child is unable to verbalize details of the assault.

Teen STI Testing

- Patient has experienced penetration, however slight, or there is evidence of acute or healed penetrative injury to the genitals, anus, or oropharynx.
- Patient exhibits signs and/or symptoms of an STI (e.g., vaginal discharge or pain, genital itching or odor, urinary symptoms, abdominal pain, and genital lesions or ulcers).
- A sibling or relative or adult in the patient's environment has an STI.
- The assailant has a known STI or is at high risk for STIs (e.g., IV drug use, multiple sex partners, men who have sex with men, history of incarceration, or history of STIs).
- The assailant is a stranger.
- Patient lives in an area with a high rate of STIs in the community.
- The patient is requesting testing.
- Patient has already been diagnosed with one STI.
- Unclear history and there are reasons to believe patient is at risk for acquiring an STI.
- Follow up is difficult or unlikely.
- Patient is sexually active.

Recommended STI Testing

- Urine NAAT gonorrhea, chlamydia
  - or vaginal NAAT (girls)
  - or urethral discharge (boys)
- Rectal NAAT gonorrhea, chlamydia
- Pharyngeal NAAT gonorrhea, chlamydia
- Urine trichomonas RNA TMA (girls)
- Hepatitis B surface antigen, surface antibody and core antibody
- Syphilis IgG and IgM antibody
- HIV antibody

STI Testing

NAAT

- Easy to obtain both in terms of patient specimen collection and offered by healthcare facility labs
- Risk of a false positive when test is performed in a population where the infection is uncommon

Culture

- Fastidious organisms (N. gonorrhea plate at room temperature)
- Specimen more difficult to transport (chlamydia culture on ice, N. gonorrhea plate at room temperature)
- Gold standard

Recommended STI Testing in Prepubertal Children

- Per CDC MMWR STI 2021 recommendations, “Culture or NAAT can be used to test for N. gonorrhoeae and C. trachomatis”
- All presumptive culture isolates of N. gonorrhoeae should be identified definitively by at least two tests that involve different approaches (e.g., biochemical, enzyme substrate, or molecular probes)
- When a NAAT specimen is positive, the result should be confirmed either by retesting the original specimen or obtaining another.
- Testing for T. vaginalis should not be limited to girls with vaginal discharge if other indications for vaginal testing exist

Should you provide STI prophylaxis?
Should you provide STI treatment?

Sexually Transmitted Infections Identified In Children

- ALWAYS make sure that a confirmatory test is performed before treating
- Consider consultation with a child abuse pediatrician or pediatric infectious disease specialist
- Report suspected child abuse

Other Presentations of Child Sexual Abuse

Physical Symptoms That May Be Related to Sexual Abuse

- Stress induced headaches or stomachaches
- Pain in the anogenital area
- Anogenital bleeding
- Genital discharge
- Anogenital injury
- Dysuria/urinary tract infections
- Constipation/encopresis (incontinence of stool)
- Enuresis (incontinence of urine; day or nighttime)
- Pregnancy
- None

Injury as an indicator of sexual assault

- 3 year old is brought to the primary care provider with injury to her face.
- Caregiver said child was standing on toilet looking in mirror and fell.
- Caregiver also reported that the child had vaginal bleeding.
- Exam revealed no external injury to labia, perineum, or anal area but hymenal tear.

Anogenital Injuries

Blunt force trauma

- Involve the external structures (labia majora, labia minora)
- If accidental, mechanism of injury should explain the findings
- Injury occurs when tissue is crushed between the bony pelvis and an object (fall onto bathtub ledge)

Penetrating Trauma

- Involve the hymen/vagina or anus/rectum
- If accidental, mechanism of injury should explain the findings
- Sexual assault injuries can be the result of penetrating trauma

Accidental Straddle Injury – Child gave clear history of falling onto the bar of the bicycle

Accidental Penetrating Injuries

- Uncommon
- Direct, forceful penetration of an object into the vagina or rectum
- Should be clear history of impalement

Findings highly suggestive of abuse

- Findings highly suggestive of abuse, unless a clear and convincing history of accidental trauma, straddle injury, impalement injury or crush injury is provided, include acute injuries to the anogenital structures, **injuries to the hymen**, vagina, posterior fossa, perianal laceration with exposure to the tissues below the dermis, or **healed transections of the hymen**).
- Does the mechanism of injury provided explain the medical findings?

Kellogg ND, Farst KJ, Adams JA, Interpretation of medical findings in suspected child sexual abuse: An update for 2023, Child Abuse & Neglect, Volume 145(2023), 106283, https://doi.org/10.1016/j.chiabu.2023.106283.

Adams JA, Farst KJ, and Kellogg ND. (2018). Interpretation of Medical Findings in Suspected Child Sexual Abuse: An Update for 2018. J Pediatr Adolesc Gynecol 31: 225-231.

Case: STI as indicator of SA

- A 6 year old girl develops a copious vaginal discharge.
- Urine PCR is obtained, and is positive for Neisseria gonorrhoeae.
- Mom and provider ask the child, “did anything happen to your private parts that you didn’t like or didn’t understand?”
- The girl reports sexual abuse (penile vaginal contact) by her stepfather occurring over the last year.

Case:

- A 6 year old girl develops a copious vaginal discharge.
- Mom brings her to the clinic.
- What do you do?

Case: STI Testing

- Urine NAAT gonorrhea, chlamydia
  - or vaginal NAAT (girls)
- Urine trichomonas RNA TMA (girls)

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Implications of Commonly Encountered STIs for diagnosis and reporting of sexual abuse among infants and prepubertal children

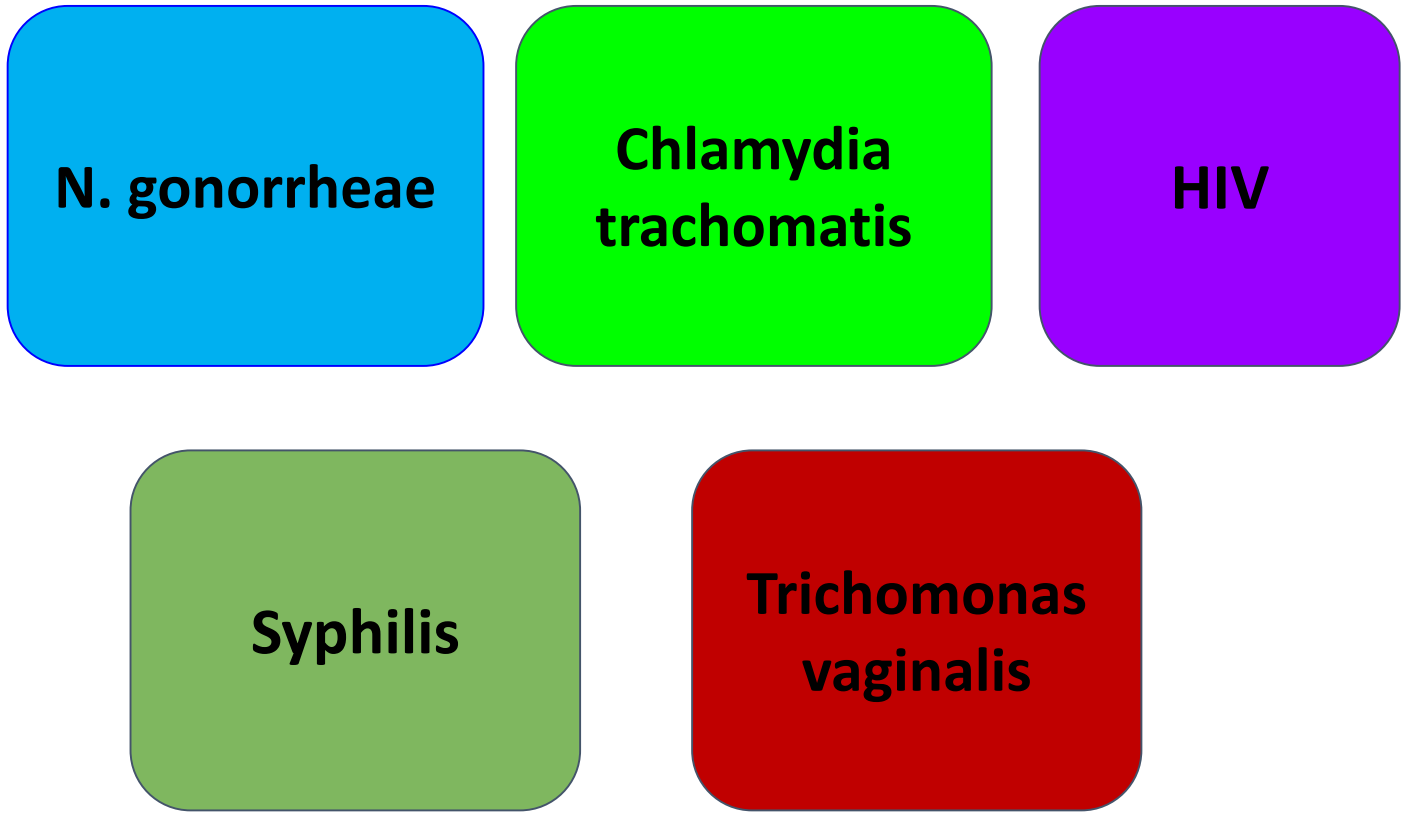
ST/SA Confirmed	Evidence for Sexual Abuse	Suggested Action
Neisseria gonorrhoeae[a]	Diagnostic	Report[b]
Syphilis[a]	Diagnostic	Report[b]
Human immunodeficiency virus[c]	Diagnostic	Report[b]
Chlamydia trachomatis[a]	Diagnostic	Report[b]
Trichomonas vaginalis[a]	Diagnostic	Report[b]
Anogenital herpes	Suspicious	Consider report[b,d]
Condylomata acuminata (anogenital warts)[a]	Suspicious	Consider report[b,d,e]
Anogenital molluscum contagiosum	Inconclusive	Medical follow-up
Bacterial vaginosis	Inconclusive	Medical follow-up

[a]If not likely to be perinatally acquired and rare vertical transmission is excluded.
[b]Reports should be made to the local or state agency mandated to receive reports of suspected child abuse or neglect.
[c]If not likely to be acquired perinatally or through transfusion.
[d]Unless a clear history of autoinoculation exists.
[e]Report if evidence exists to suspect abuse, including history, physical examination, or other identified infections. Lesions appearing for first time in child >5 years of age are more likely attributable to sexual transmission.

Table adapted from Kellogg N; American Academy of Pediatrics, Committee on Child Abuse and Neglect. The evaluation of sexual abuse in children. *Pediatrics.* 2005;116(2):506–512 (Updated 2013 clinical report [reaffirmed August 2018] available at **https://doi.org/10.1542/peds.2013-1741**) and Centers for Disease Control and Prevention. Sexually transmitted infections treatment guidelines, 2021. *MMWR Recomm Rep.* 2021;70(RR-4):1-187. Available at: **www.cdc.gov/std/treatment-guidelines/sexual-assault-children.htm.**

American Academy of Pediatrics Red Book
https://doi.org/10.1542/9781610027373-S2_005_003

Infections *Diagnostic* for Sexual Abuse if unlikely to be perinatally acquired and rare vertical transmission is excluded



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Primary Syphilis Chancre

- Single sore or multiple
- Sores/ulcers are usually (but not always) firm, round, without exudate, and painless
- Atypical lesions can frequently be seen, with one study reporting that of patients with primary syphilis only 42.7% had a “classic” single lesion
- Multiple lesions occur more frequently than previous reported, especially in persons living with human immunodeficiency virus (HIV)
- There may be regional lymphadenopathy
- Sometimes goes unnoticed
- Lasts 3 to 6 weeks and heals regardless of whether treatment is received

Manifestations of Primary Syphilis

New York City Department of Health and Mental Hygiene, and the New York City STD Prevention Training Center. The Diagnosis and Management of Syphilis: An Update and Review. March 2019. www.nycptc.org.

Secondary Syphilis

- **Lesions of secondary syphilis generally occur 4 to 8 weeks after the appearance of the primary ulcer**
- **In some patients presenting with evidence of secondary syphilis, the primary lesion will still be present**
  - **Since T pallidum best proliferates in lower temperatures, most clinical signs and symptoms present as skin and mucous membrane eruptions**
- **Diffuse maculopapular skin rash involving the trunk, extremities, palms, and soles**
- **Condyloma lata**
  - **large, raised, gray or white lesions**
  - **develop in warm, moist areas like the mouth, underarm or groin region**
- **Flu like symptoms:**
  - **Fever, swollen lymph glands, sore throat, muscle aches, fatigue**
- **Hepatitis, patchy alopecia, weight loss and renal insufficiency**
- **Ocular manifestations can include uveitis, retinitis, and optic neuritis**
- **Invasion of the CNS (as manifested by aseptic meningitis, cranial neuropathies)**

Manifestations of Secondary Syphilis

New York City Department of Health and Mental Hygiene, and the New York City STD Prevention Training Center. The Diagnosis and Management of Syphilis: An Update and Review. March 2019. www.nycptc.org.

Condyloma Latum

Case: STI as indicator of SA

- A 7 year old girl tells mom that there is blood on the toilet paper.
- Mom takes the child to the clinic, and a large genital wart is noted next to urethra.
- Mom and provider ask the child, “did anything happen to your front private area that you didn’t like or didn’t understand?”
- The girl reports sexual abuse (penile vaginal contact) by her stepfather occurring over the last year.

Infections *Suspicious* for Sexual Abuse

Anogenital warts (Condyloma acuminata)

- **if unlikely to be perinatally acquired**
- **if vertical transmission is unlikely**
- **if autoinoculation is unlikely**

Herpes

- **if autoinoculation is unlikely**

American Academy of Pediatrics Red Book https://doi.org/10.1542/9781610027373-S2_005_003

Genital warts causing bleeding when child wiped with toilet paper

Two children who both disclosed sexual abuse by same offender

Perianal warts

Case: STI as indicator of SA

- A 15 year old girl sought treatment for painful genital ulcers on the labia majora.
- She was discharged with a diagnosis of “aphthous ulcers” and given a prescription for Acyclovir.
- Mom went to the pharmacy to fill the prescription, and recognized that Acyclovir is treatment for Herpes. She asked the teen how she got herpes, and the teen disclosed that she was having sexual intercourse with an adult man in his 50’s.
- Mom called the police.
- Teen reported at the time of CAC visit that there was oral vaginal contact two weeks prior to the herpes diagnosis.
- The girl subsequently had another outbreak and PCR of the lesions was positive for HSV 1.

From: **Herpes Simplex**

Red Book® 2018, 2018

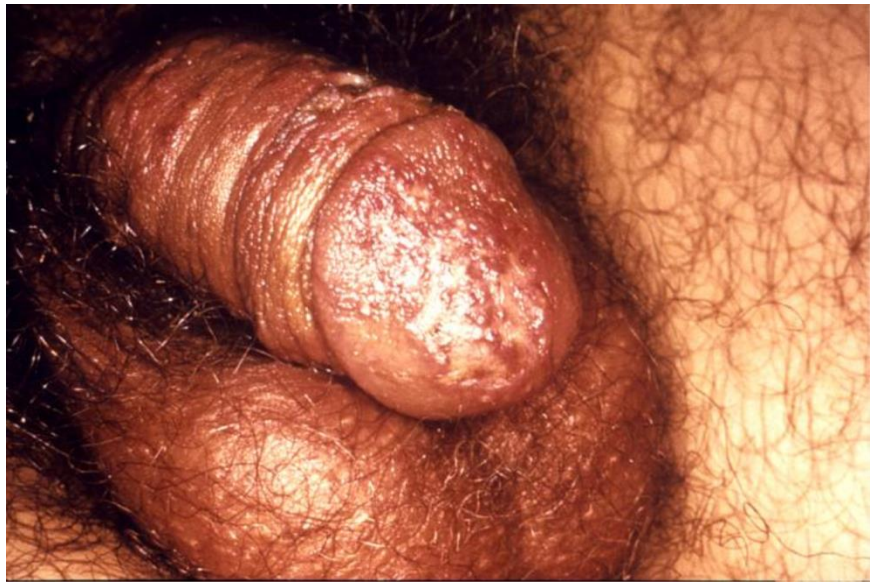


Figure Legend:

This male presented with primary vesiculopapular herpes genitalis lesions on his glans penis and penile shaft. When signs of herpes genitalis do occur, they typically appear as one or more blisters on or around the genitals or rectum. The blisters break, leaving tender ulcers (sores) that may take 2 to 4 weeks to heal the first time they occur. Courtesy of Centers for Disease Control and Prevention

Herpes

Lesions typically y appear as one or more blisters on or around the genitals or rectum. The blisters break, leaving tender ulcers (sores) that may take 2 to 4 weeks to heal the first time they occur.

Approach to the Child with STI

- Confirm that the test results reflect a true positive or that the finding on exam is not a mimic (for example, not all genital ulcers are herpes)
- Obtain history : how long has the child had the lesion or discharge or symptoms of the infection?
- Could the infection be perinatally transmitted?
- Could the infection have been transmitted via blood transfusion? Needles?
- Does anyone else in the child's environment have the infection?
- Is the child reporting sexual abuse?
- Does the child have any behaviors that raise concern for sexual abuse?
- Are there other physical examination findings that raise concern for sexual abuse? (for example, hymenal transection)
- Does the child have any other sexually transmitted infections?
- Is referral to a Children's Advocacy Center or consultation with a child abuse pediatrician or pediatric infectious disease specialist indicated?

Behavioral Symptoms That May Be Associated with Sexual Abuse

- Difficulty sleeping
- Change in eating habits
- Change in school functioning
- Change in interactions with family
- Anger
- Running away
- Suicidal ideation +/- attempt
- Problematic sexual behaviors
- None

What Is Problematic Sexual Behavior? Case Discussion

- Mom brings her 4 year old son to the clinic
- She reports that he has exhibited behaviors that concern her.
- Behaviors include
  - the child grabbing his own penis
  - the child repeatedly trying to put his mouth on other peoples' private areas
  - the child trying to put his penis in his younger brother's anus
  - and the child getting upset when mom told him "no, don't put your mouth on other people's private areas and don't touch your brother."

Normal common behaviors in children ages 2-6 years

Trying to view peer/adult nudity	Touching/masturbating genitals in public/private	Behaviors are few, transient and distractible
Showing genitals to peers	Standing/sitting too close	Viewing/touching new sibling or peer genitals

Kellogg N and the Committee on Child Abuse and Neglect. Clinical Report – The Evaluation of Sexual Behaviors in Children. Pediatrics 2009; 124:992-998

Less common normal behaviors in children ages 2-6 years

Rubbing body against others	Trying to insert tongue into mouth while kissing	Touching peer/adult genitals
Crude mimicking of movements associated with sexual acts	Sexual behaviors that are occasionally, but persistently, disruptive to others	Behaviors are transient and moderately responsive to distraction

Kellogg N and the Committee on Child Abuse and Neglect. Clinical Report – The Evaluation of Sexual Behaviors in Children. Pediatrics 2009; 124:992-998

Uncommon behaviors in normal children ages 2-6 years

- Asking peer/adult to engage in specific sexual act(s)
- Inserting objects into genitals
- Explicitly imitating intercourse
- Behaviors that are persistent and resistant to parental distraction
- Sexual behaviors that are frequently disruptive to others
- Touching animal genitals

Kellogg N and the Committee on Child Abuse and Neglect. Clinical Report – The Evaluation of Sexual Behaviors in Children. Pediatrics 2009; 124:992-998

Rarely normal sexual behaviors in children ages 2-6 years

Any sexual behaviors that involve children who are 4 or more years apart

A variety of sexual behaviors displayed on a daily basis

Sexual behavior that results in emotional distress or physical pain

Sexual behaviors associated with other physically aggressive behavior

Sexual behaviors that involve coercion

Behaviors are persistent and child becomes angry if distracted

Kellogg N and the Committee on Child Abuse and Neglect. Clinical Report – The Evaluation of Sexual Behaviors in Children. Pediatrics 2009; 124:992-998

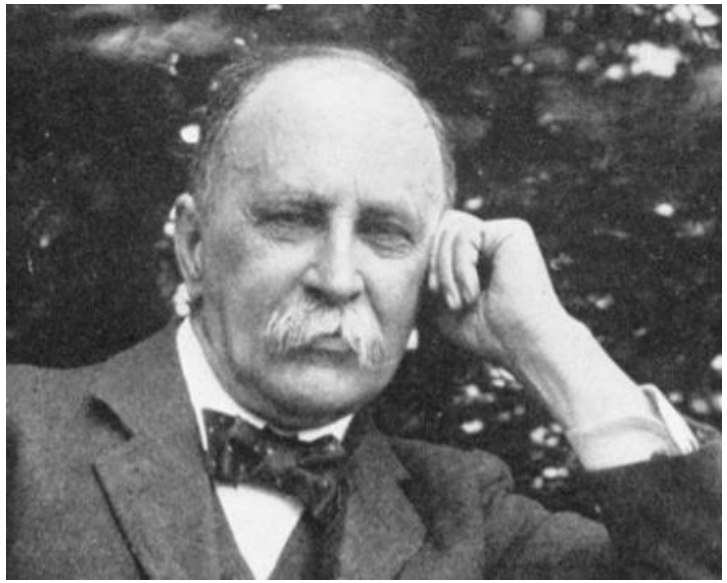
Sexual behaviors in children ages 2-6 years
Assess situational and environmental factors

Family nudity	New sibling	Violence
Physical abuse and neglect	Exposure to pornography	Exposure to inappropriate material

Kellogg N and the Committee on Child Abuse and Neglect. Clinical Report – The Evaluation of Sexual Behaviors in Children. Pediatrics 2009; 124:992-998

Reality: The Role of the Medical Provider

- Sir William Osler said, “The good physician treats the disease; the great physician treats the patient who has the disease.”

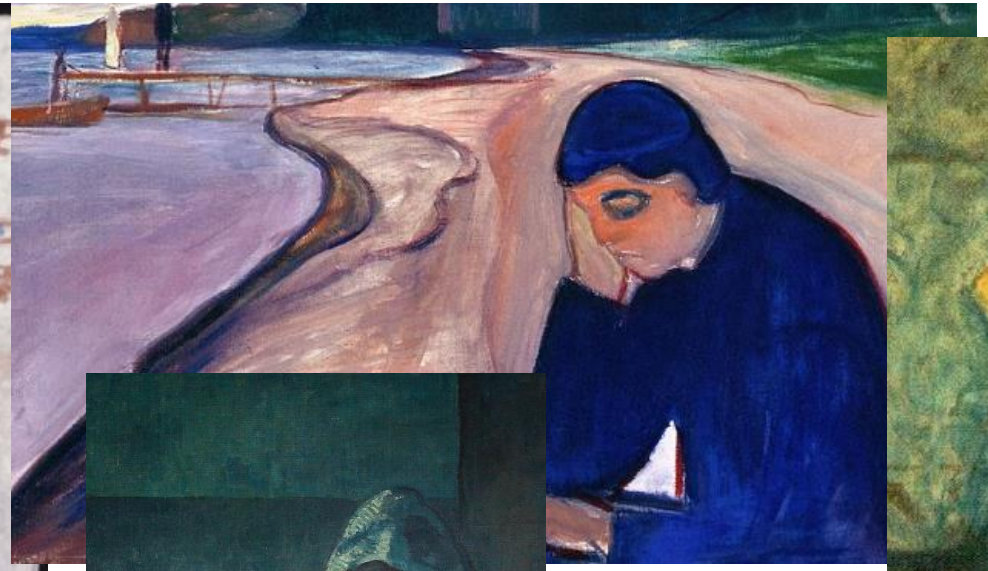


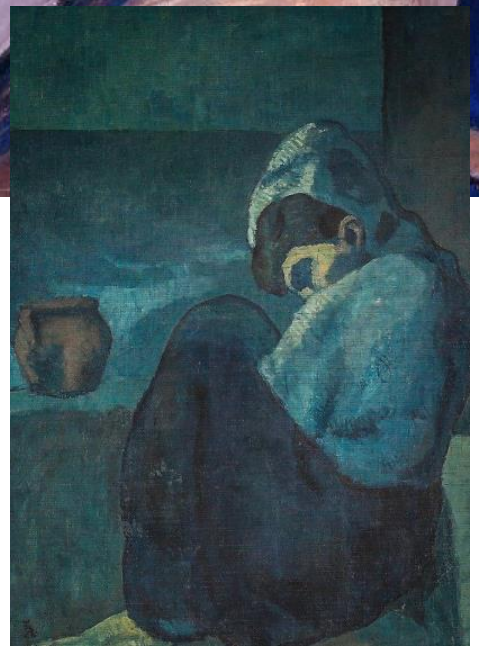
HPV (Human Papilloma Virus) vaccination

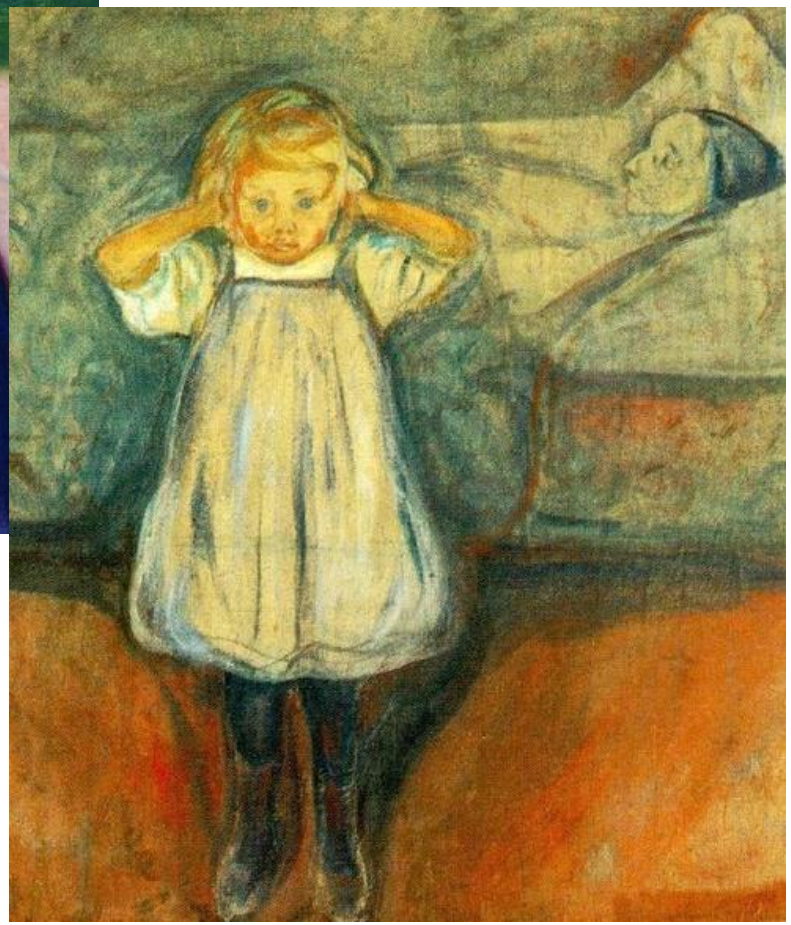
- Because HPV infections can occur as a result of sexual assault, the Center for Disease Control and prevention has recommended the HPV vaccine for sexually abused children who are age 9 years and older (Workowski et al., 2015) due to an increased risk for unhealthy or premature sexual behavior.
- An HPV vaccine can also be provided for unvaccinated or partially vaccinated adolescents presenting acutely following a sexual assault; some evidence suggests a preventative or prophylactic role for the vaccine in this clinical setting.

Negative Health Outcomes Associated with ACEs (CDC)

Address Mental Health Concerns







Response to child abuse is complex and requires multiple disciplines: Children's Advocacy Centers Can Help Coordinate Services

How do I refer a child to the CAC for medical services?

- DCBS and/or Law Enforcement must make the referral.
- Tell investigators that you recommend CAC evaluation.
- Tell the family to call the CAC.
- Call the CAC yourself.

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