

Assessment for Sexual Abuse in A Case Presenting with Genital Herpes

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ABSTRACT

Assessment for sexual abuse in a case presenting with genital herpes

Child sexual abuse is defined as the use of a child by an adult or a significantly older person for the purpose of sexual stimulation. Sexual relations within the family (incest) "particularly involving children" is prohibited in all faiths and societies; hence, incestuous child sexual abuse is the form of abuse most difficult to determine. Prepubertal genital herpes is a presentation that definitely needs to be assessed as a potential indication for sexual abuse. Even though in adults transmission is often by sexual route, it has been pointed out that especially in cases below the age of 5 years, anogenital herpes can be transmitted by non-sexual mechanisms. As paths for a possible non-sexual transmission of genital herpes, autoinoculation, finger contact by an adult changing nappies leading to infection, hand contact between children, or transmission via infected objects (plate, fork, garments, etc.) have been reported. Guidelines helping in the assessment of sexual abuse are insufficient regarding the question how the issue should be confronted in pediatric cases of genital herpes. More evidence is required to solve this problem. In our presentation, we discuss the process of assessment for sexual abuse in the case of a girl aged 2 years 3 months presenting to the emergency department with anogenital herpes.

Keywords: Genital herpes, incest, sexual abuse



ÖZET

Genital herpetik veziküllerle başvuran bir olgunun cinsel istismar yönünden değerlendirilmesi

Çocuk cinsel istismarı; çocuğun bir yetişkin veya yaşça büyük bir kişi tarafından cinsel uyarı amacıyla kullanılması olarak tanımlanmaktadır. Aile içi cinsel ilişkinin (ensest) "özellikle de çocuğa yönelik olanın" tüm inanç sistemlerinde ve toplumlarda yasaklanmış olması nedeniyle çocuğun cinsel istismarı, istismarlar içerisinde en zor saptanabildir. Genital herpes, prepubertal dönemde cinsel istismar bulgusu olabileceğinden mutlaka değerlendirilmesi gereken bir durumdur. Yetişkinlerde cinsel yolla bulaş fazla olmasına rağmen özellikle 5 yaşın altındaki olgularda anogenital herpesin cinsel olmayan yolla da bulaşabildiği bildirilmektedir. Genital herpesin olası cinsel olmayan bulaş yolları; otoinokulasyon, alt bezleme sırasında bakım veren erişkinden parmak teması ile bulaş, çocukların birbirine elle teması, enfekte nesnelere bulaş (tabak, çatal, elbise vb.) olarak bildirilmektedir. Cinsel istismar değerlendirmede yardımcı olan kılavuzlar, pediatrik genital herpes olgularının cinsel istismar yönünden nasıl ele alınması gerektiği konusunda yetersiz kalmaktadır. Bu konuda daha fazla kanıt gereksinim vardır. Bu sunumda anogenital herpes nedeniyle acil servise başvuran 2 yaş 3 aylık bir kız olguda cinsel istismar açısından değerlendirilme süreci sunulmuştur.

Anahtar kelimeler: Genital herpes, ensest, cinsel istismar

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INTRODUCTION

The National Center for Child Abuse and Neglect has defined child sexual abuse (CSA) as "contact or interaction between a child and an adult when the child is used for the sexual stimulation of an adult or another person" (1). According to various studies, around 20-25% of sexual abuse cases involve incest

(2). As a cumulative definition from the latest studies, incest is said to be any verbal or non-verbal, physical, or visual erotic behavior between family members except between the spouses. As in other parts of the world, in Turkey incest cases mostly remain hidden (3). Clinicians dealing with sexual abuse are confronted with presentations such as stomach ache, rectal bleeding, history of fall astride injury, chronic or

recurrent urinary tract infection, as well as other somatic complaints, pregnancy, or behavioral problems. In addition, it is important to assess cases of bleeding or foreign body in vagina or rectum, condyloma acuminatum, genital herpes, trichomoniasis, gonococcal vulvovaginitis and other sexually transmissible diseases in children under the aspect of CSA. History received from the child always has to be the fundamental means of diagnosis (4). Genital herpes in children is very rare. It can present as an acute rash in the diaper region or with vulvar ulceration (5). The most common route of HSV transmission is perinatal through contact of the fetus with secretion from the mother carrying a genital infection. From the United States, it is reported that 80% of the population have encountered HSV-1 during childhood. The increase of asymptomatic HSV-1 infection prevalence in the general population leads to a rise in infections of newborns via oropharyngeal route (5-7). Given that genital herpes in the prepubertal period may constitute a sign of sexual abuse, it definitely requires assessment, but because of the increased HSV-1 infection prevalence, it needs to be pointed out carefully to the child and the parents, when being directed towards the child psychiatry unit, that there are other possible infection routes. In this paper, we describe the process of assessment for sexual abuse of a girl aged 2 years and 3 months admitted to emergency for anogenital herpes.

CASE

A girl aged 2 years and 3 months presented to the Pediatric Emergency Service of Dokuz Eylul University Faculty of Medicine (DEUFM) with complaints of painful blisters in the gluteal region, unable to sleep during the night. During physical examination, herpetic blisters were found; for an assessment of sexual abuse, a consultation at the DEUFM Department of Child and Adolescent Psychiatry was requested. In the process, a consultation at the DEUFM Department of Dermatology was also requested, recommending Tzanck smear test to assess viral cytopathologic changes consistent with herpes, and typology by antibody

assay. At the same time, psychiatric evaluation of the patient and her family was started. In the physical examination, apart from the herpetic blisters in the gluteal region, no results suggesting any kind of abuse had been found. Receiving the patient history, it was learned that the vesicular lesions had begun around two months earlier and increased over time. It was reported that no one else in the family had similar lesions, but on the mother's lip, sores frequently erupted.

As to the family history, the parents were living together and did not identify any problems between them. The mother was a housewife aged 34, the father a 33-year-old hauler; the patient had two siblings aged 5 and 7 years who did not have any adaptation problems. It was reported that they lived in a family condominium; the mother was looking after the patient, and in her absence, the paternal grandmother took care of the child. In the first assessment, serology of other sexually transmitted diseases was requested. Serological results for HBsAg, AntiHBcIgM, AntiHBctotal, AntiHBs, AntiHCV, HIVAg/Ab, Anti-Tpallidum IgM and IgG, and Chlamydia Trachomatis IgG and IgM were all negative. Aerobic genital swab and aerobic stool culture produced normal flora bacteria. HSV serotyping results were negative for HS-2IgG, positive for HSV-1IgG, borderline for HSV 1+2IgM.

In the psychiatric interviews, it was noted that the mother's verbal articulateness was limited, she could not give detailed information about the child's developmental stages, while the father showed a defensive attitude and became angry during the interview.

Assessment of the child's mental state showed a state consistent with her physical appearance; her garments and hygiene were adequate, she spoke adequately for her age and development, and in response to the circumstances behaved somewhat agitated and curious. Her reaction to the separation from her parents was age-adequate and she spontaneously engaged in social relations. She responded to the alien environment age-adequately with explorative behavior and reacted to the separation from the parents according to her age. She established

verbal relations by herself, and her language understanding and expression were adequate for her age. There were no abnormalities in speaking rate, fluency, rhythm, or intonation. Her hearing gave a normal impression. Affective responses were appropriate for the situation and conditions and quite rich. Her mood was mildly anxious, she was fully conscious and oriented, and during the event, her attention span was as expected for her age. There were no abnormalities in memory and perception, her intelligence gave an age-adequate impression, and her judgment and abstract thinking development levels were assessed as adequate.

To evaluate the child's psychomotor development, Ankara Development Screening Inventory and Denver II Tests were requested (8,9), and both instruments established a development level consistent with her age.

After psychiatric assessment, the patient did not show any other psychiatric symptom for sexual abuse, nor any indication for delay in development or physical signs; thus, it can be assumed that the herpetic lesions, with a positive serological result for HSV-1, were caused not by sexual infection but through non-sexual virus transmission from her mother.

DISCUSSION

Genital herpes is a viral infection caused by HSV. There are two types of HSV: The most commonly seen HSV-1 infection (85% of the total) affects skin and mucosa outside the genital region, while HSV-2 causes illness in the mucosa and skin of the genital and anal region. However, in around 10-20% of the cases, an HSV infection develops with a different virus type according to the region. In years past, most genital infections were caused by HSV-2. Today, HSV-1 and HSV-2 can be found in this presentation with equal frequency (10,11). With the presence of genital herpes, especially in children, it is necessary to consider sexual abuse. In that case, patient and family need to be assessed psychiatrically for sexual abuse, an adequate dermatological consultation should be requested, and potential other sexually transmitted diseases should be investigated. There is no established procedure for this

issue. Signs for sexual abuse vary with age, and clinical presentations can be in different forms. Changes in behavior can be an expression of sexual abuse, as generally specific stress factors result in specific responses. In children from 0-3 years of age, eating and sleeping disorders, fear of strangers and sexual play inadequate for their age can be observed. In 3-year-old children, baby talk, intraversion, enuresis, encopresis, eating and sleeping disorders, aggression, submissive behavior, continuous sexual play and frequent masturbation can be seen (12). Genital herpes in children under the age of 11 is rarely seen, with a rate of about 1/1000000. In one-third of these cases, no viral investigation was established, and in a very small fraction, other sexually transmitted diseases were found (13). While in adults, sexual transmission is common, it has been reported that in cases below the age of 5, anogenital herpes can be contracted by non-sexual routes.

The literature on this topic is insufficient. In the existing literature, it has been reported that in examinations of children with herpetic lesions in England, HSV-1 was found to be more common than HSV-2 (14), which also indicates that non-sexual infection is more common (13). When encountering genital herpes, it is important to carry out HSV serotyping. In the literature, there is little information about the serotypes of genital herpes. In a presentation assessing 16 individuals with genital herpes, in 13 cases HSV-1 was found, in one case both HSV-1 and HSV-2, in one person HSV-2, and in one case viral cytopathology was not done (13). Non-sexual transmission paths reported for genital herpes include autoinoculation, finger contact by an adult changing nappies leading to infection, hand contact between children, or transmission via infected objects (plate, fork, garments, etc.) Evidence for sexual transmission is weak. Sexual transmission is more commonly reported in children above the age of 5, with genital lesions only and with isolation of HSV-2 (15).

Our case was still using nappies, the mother frequently developed sores, and the child was under the age of 5, which made us think of a non-sexually transmitted infection. The requested HSV serotyping

found HSV-1. Interviews with family and patient and assessment of the patient's development found no indications for abuse, and the patient was also assessed for emotional neglect and abuse. In the light of all these data, we assume that the patient had contracted genital herpes in a non-sexual way.

Pediatric cases of anogenital herpes necessarily have to be investigated for sexual abuse, but the investigation has to be done cautiously; we have to keep in mind

that it is imperative to make child and family understand why they are being referred to the child psychiatry unit. While anogenital herpes can be transmitted sexually, there are other ways of infection, as we have seen in our case.

Guidelines helping in the assessment of sexual abuse are insufficient in explaining how pediatric genital herpes cases should be investigated for sexual abuse. More evidence for this issue is needed.

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