Pediatric SANE Exam Tips

One of the most invaluable benefits of the medical forensic examination is its power to promote children's healing. In many situations, children leave the exam room feeling empowered, having learned information about their bodies and been reassured that they are healthy. The vast majority of children who experienced sexual abuse—over 90 percent—have normal examinations (Adams, 2003; Berkoff et al., 2008; Heger et al., 2002; Kellogg, 2005). When findings are abnormal, medical forensic care can facilitate the treatment needed to allow children to regain their health. The exam process also provides the opportunity to begin to address children's needs related to safety, justice, and support. It is important that examiners educate the multidisciplinary response team about the positive impact that medical forensic care can have for children and their families. This knowledge allows team members to address misconceptions that children, caregivers, or others may have about the examination and to explain its benefits.

Keep the focus of the examination on the entire child. The medical forensic examination in a prepubescent child sexual abuse case includes a physical examination augmented by an anogenital examination. This approach allows examiners to assess for all types of abuse and neglect, not just sexual abuse.

Explain the overall examination to the child and caregiver prior to the examination, as well as specific procedures during the examination. The examination is a thorough physical evaluation, similar to an annual pediatric well-check visit.

- The examination is typically painless. It will include an examination of the genital and anal area. A speculum will not be used. Sedation or anesthesia is necessary only in rare situations in which there are concerns of significant anogenital bleeding or injury, a mass, or a foreign body.

- Photographic images will be taken to document the physical findings and ensure the accuracy of the interpretation of these findings. The images will be securely stored at the health care facility and access to them is controlled.

- The child is in control of what happens during the examination. The health care provider will explain what is happening during the different steps of the examination. If the child expresses an interest, exam equipment can be demonstrated. Questions are encouraged and breaks can be taken whenever needed.

In most instances, when examiners establish rapport with children, explain exam procedures to them, and welcome their questions, children are able to complete the examination without difficulty.

Recognize that medical components of the examination cannot be separated from evidentiary components. In acute cases, pediatric examiners must be prepared to incorporate forensic sample collection into the physical and anogenital examination as it proceeds.

Clarify who can be in the exam room beyond the child. A parent, guardian, or primary caregiver should be present during the anogenital exam. This is necessary during the forensic examination as a safeguard for children, due to their vulnerability to abuse, and to protect staff. Limit the number of persons to the pt,

one guardian/family member in the exam room, SANE, and peds MD to protect patient privacy and simply because the room often cannot accommodate more than a few individuals.

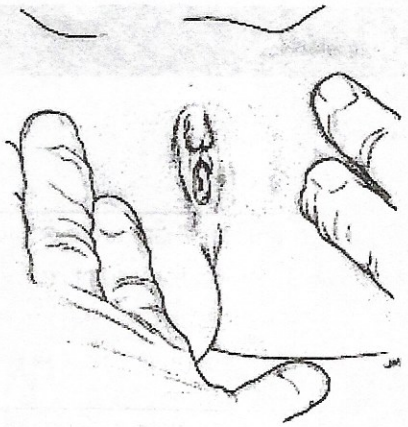
Conduct a head-to-toe examination, as summarized below. The examination should proceed in a way that affords as much dignity, privacy, and comfort to the child as possible. Limit exposure of the body to the area being examined (e.g., when observing the breast, only expose that particular area). Note that an alternate light source (ALS), can aid in examining the body, hair, and clothing.

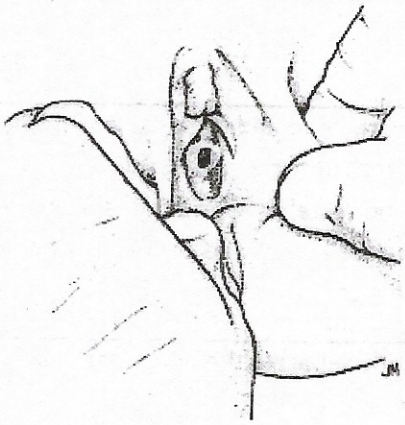
Head-to-Toe Exam Steps
Note the child's general appearance, demeanor, and developmental stage. Document Tanner Stage.
Inspect the head and scalp. Observe for areas of missing hair and evidence of bruising/petechiae on the scalp.
Inspect the eyes. Observe for areas of bruising around the eyes (may be subtle). Look for the presence of conjunctival petechiae or hemorrhage.
Inspect the external and internal ears. Do not forget the area behind the ears, for evidence of shadow bruising or battle signs (which may be a sign that a skull fracture exists). Bleeding or leakage of cerebrospinal fluid (CSF) from the ear may also indicate skull fractures.
Inspect all surfaces of the child's neck for injury. Injuries observed on the neck can indicate a possible strangulation event warranting further questions by the provider.
Assess the child's hands, inspecting all sides for injury. Observe general appearance. Observe wrists for signs of ligature marks.
Inspect the child's forearms, upper arms, and axilla for injuries or intravenous puncture sites.
Examine the anterior and posterior aspects of the legs, paying special attention to the inner thighs for injury. Observe for injury and foreign materials. Assess for tenderness. Assess the feet and ankles for similar injury, foreign materials, and tenderness, including the soles of the feet.
Inspection of the posterior aspects of the legs may be easier to achieve with the child standing or sitting on the caregiver's lap. Alternatively, the child may be examined in a supine position and asked to lift each leg in turn and then rolled slightly to inspect each buttock.
Obvious physical deformities should be noted. Piercings and other markings should be noted
Conduct the anogenital examination. The anogenital examination focuses on the external genitalia of prepubescent boys and the labia and contents of the vestibule of prepubescent girls. The presence of a chaperone for the child is particularly important during this part of the examination. A speculum examination of the vagina is not indicated for a prepubescent girl with an unestrogenized hymen unless there are concerns of bleeding, a mass, or a foreign body. If an intra-vaginal examination is required, sedation or anesthesia must be used. In this case, consult pediatric attending.

Use specific exam positions and techniques to facilitate the examination of genitalia in prepubescent children. Note that modifications may be needed for children with mobility impairments, as indicated by the medical history.

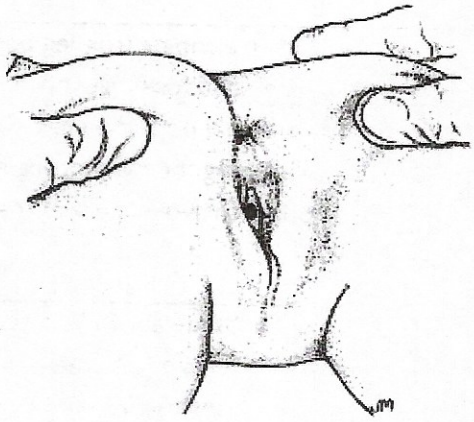
Exam Positions and Techniques

Supine Labial Separation





Supine Labial Traction



Prone Knee- Chest

Position/ Technique	Description
Supine frog-leg position	The child lies on the exam table or lap of a caregiver, with feet close together and knees loosely apart. Allows for visualization of the labia, and ease of use with labial separation and traction techniques. Allows for view of vulva, hymen, and vestibule. Abnormalities should be confirmed in prone knee-chest position (Kellogg, 2011).
Supine knee-chest position	The child lies on the exam table or lap of a caregiver, with feet and knees together holding knees to chest (may need assistance). Allows for visualization of the anus and surrounding tissues.
Prone knee-chest position	The child is on exam table in a prone position, with head and torso flush with the table, knees separated and down on the exam table, and buttocks raised. Allows for visualization of the anus, surrounding tissues, and rectal cavity during relaxation.With use of labial separation and traction, allows for assessment and confirmation of hymenal findings visualized while the child was in supine frog-leg.
Labial separation technique	With the child in a supine frog-leg position, gently separate the child's labia with gloved hands. Allows for visualization of the genital structures.
Labial traction technique	With the child in a supine frog-leg position, gently hold the child's labia majora bilaterally between thumb and forefingers with gloved hands, pulling out toward the examiner and down toward the anus of the child. This technique allows visualization of the genital structures including the hymen, vaginal opening, and posterior fourchette areas. Care should be taken to avoid injury of the posterior fourchette before, during, and after the examination.
Floating hymen technique	If the hymeneal tissue appears folded on itself or adhered together, the use of saline to moisten the hymen's edges may improve visualization, allowing a more complete assessment. This technique can be performed with the child in prone knee-chest position with gluteal lift (Adams et al., 2015; Kellogg, 2011).

For children who are anxious about the anogenital examination, consider if there may be modifications that could ease their anxiety. For example, if the child is hesitant to remove her/his underwear or clothing, ask the child if the caregiver could help. In acute cases, examiners can give the caregiver gloves to use and provide instruction to preserve forensic evidence during removal. It might be reassuring for an

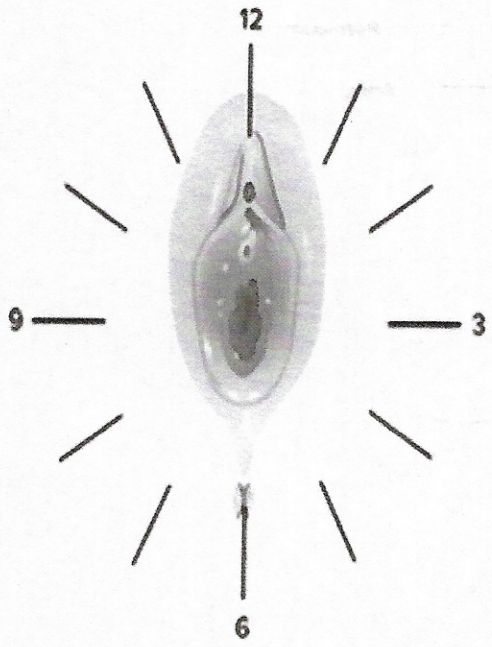
anxious child to be examined on a caregiver's lap rather than on the exam table (see above positions). If children decline the anogenital examination altogether, they may still allow the physical examination and swabs of the head, neck, chest and abdomen. They may allow underpants to be collected, especially if new underpants are provided.[11]

Genital Examination of Prepubescent Girls

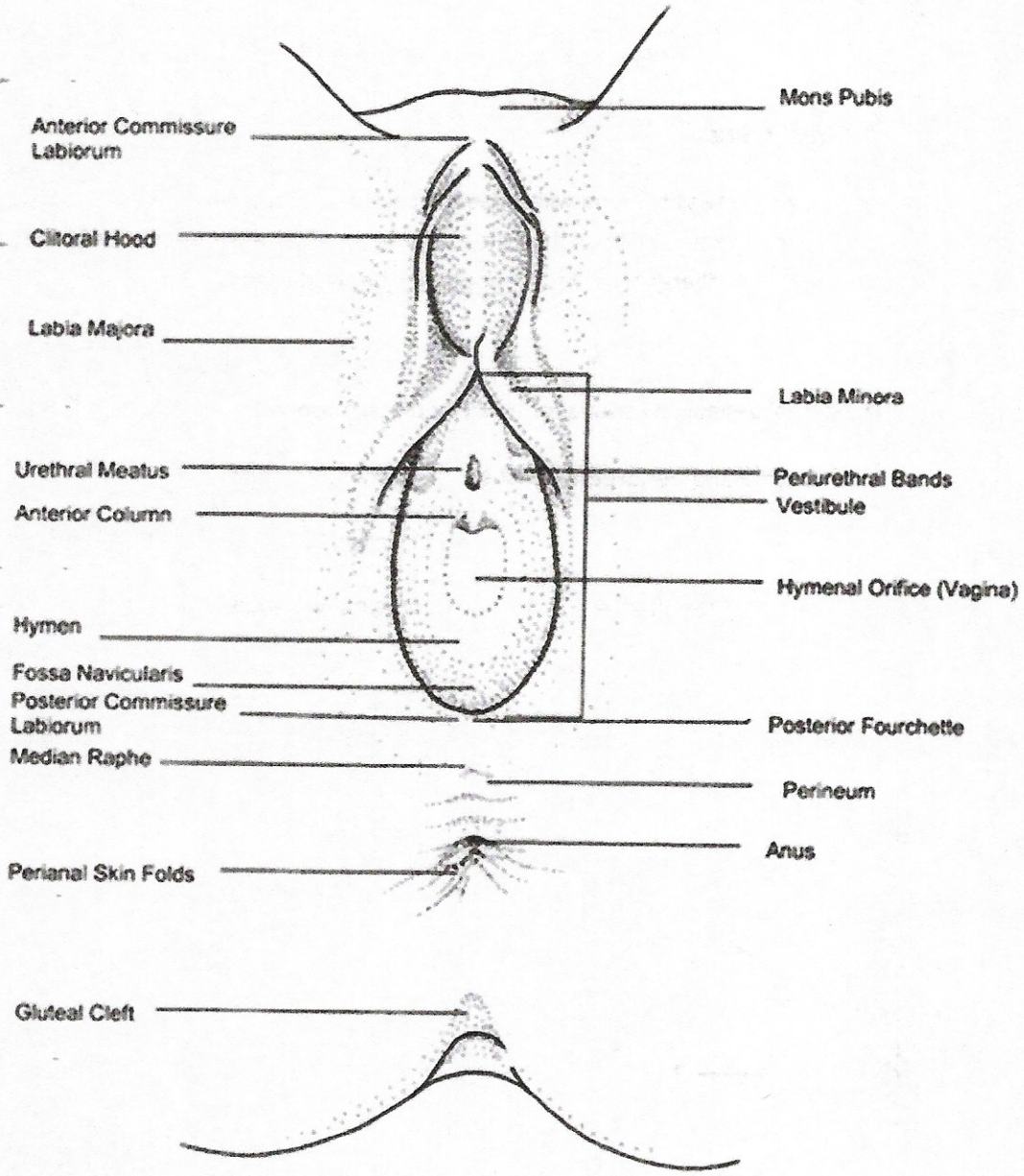
Note the hymen of prepubescent girls is sensitive and will cause the child pain if touched. Techniques used in postpubertal girls for hymenal assessment, such as the cotton-tipped swab to examine edges of the hymen or the urethral (Foley) balloon catheter technique, should not be used with prepubescent girls.

In girls, assess the following external genital structures for injury or disease process:

- Mons pubis
- Labia majora and minora
- Clitoral hood and clitoris
- Urethra and periurethral tissues
- Perineum
- Posterior fourchette
- Fossa navicularis
- Hymen
- Vaginal vestibule



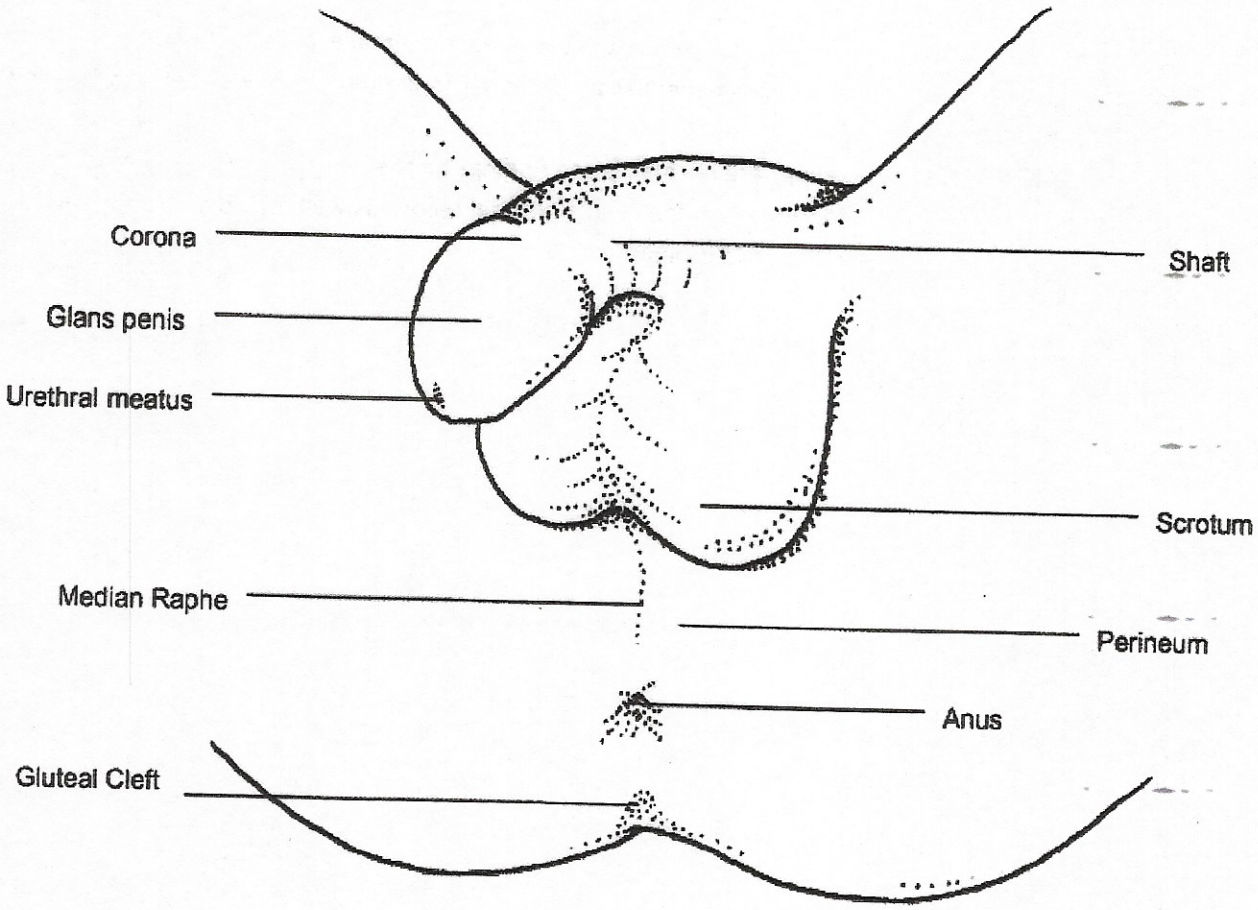
Female Genital Anatomy


Mons Pubis
Anterior Commissure Labiorum
Clitoral Hood
Labia Majora
Labia Minora
Urethral Meatus
Periurethral Bands
Anterior Column
Vestibule
Hymenal Orifice (Vagina)
Hymen
Fossa Navicularis
Posterior Commissure Labiorum
Posterior Fourchette
Median Raphe
Perineum
Anus
Perianal Skin Folds
Gluteal Cleft

Include the following structures and tissues in the genital examination of boys, checking for signs of injury or disease process (see below for illustration):

- Prepuce of the glans
- Glans penis and frenulum
- Urethral meatus
- Penile shaft
- Scrotum
- Testes
- Inguinal region
- Perineum

Male Genital Anatomy



Anal Examination of Girls and Boys

Utilize either the supine or prone knee-chest positions to examine the anus of children. In either position, apply gentle traction to part the buttock cheeks. **Inspect the following tissues and structures during the anal examination, looking for signs of injury or disease process:**

· Perianal area, paying particular attention to the perianal folds

· Anal verge/margin

· Anorectal canal

· Anus

· Gluteal cleft

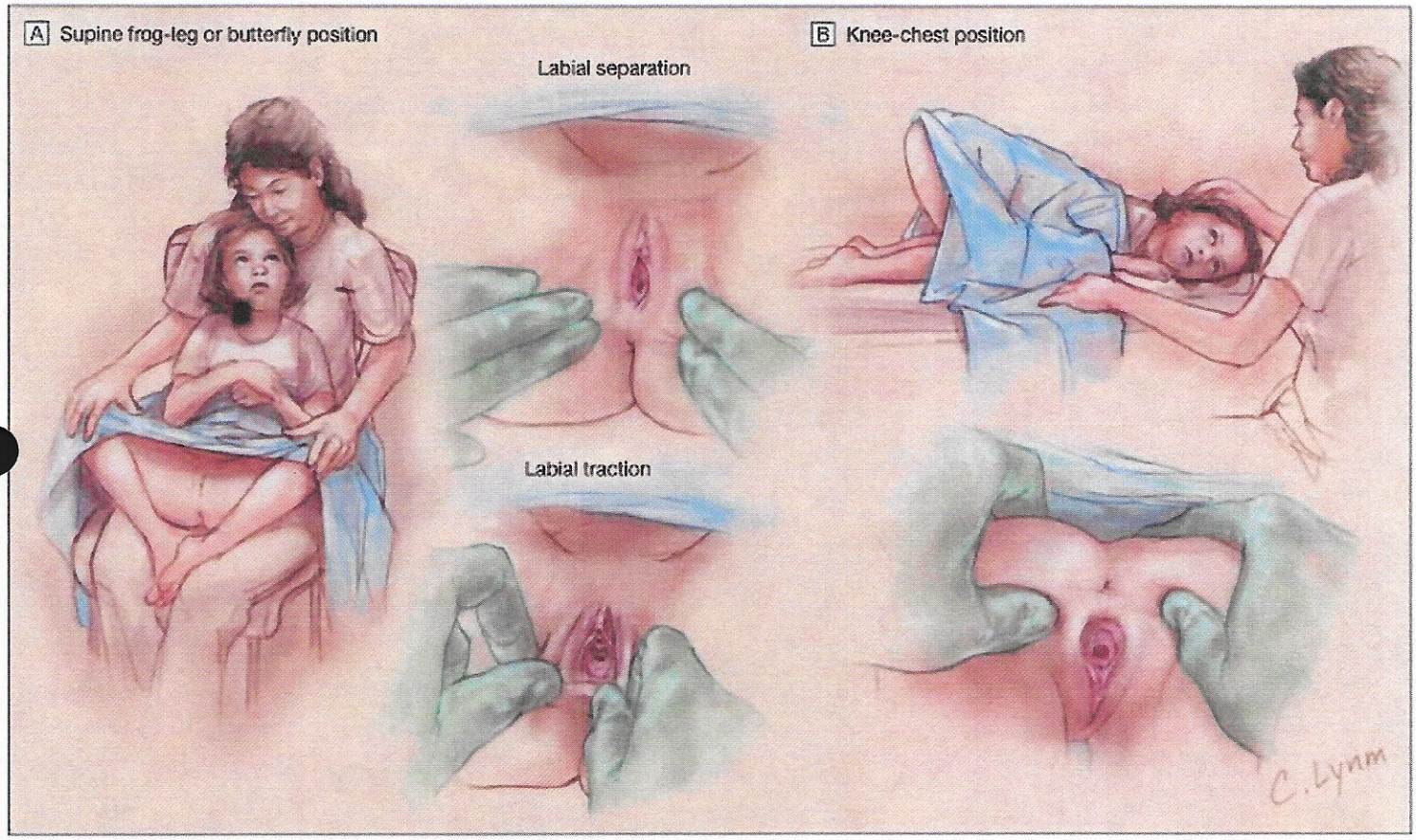
A digital examination should only be performed where laxity of the sphincter is observed.

Interpretation of Exam Findings

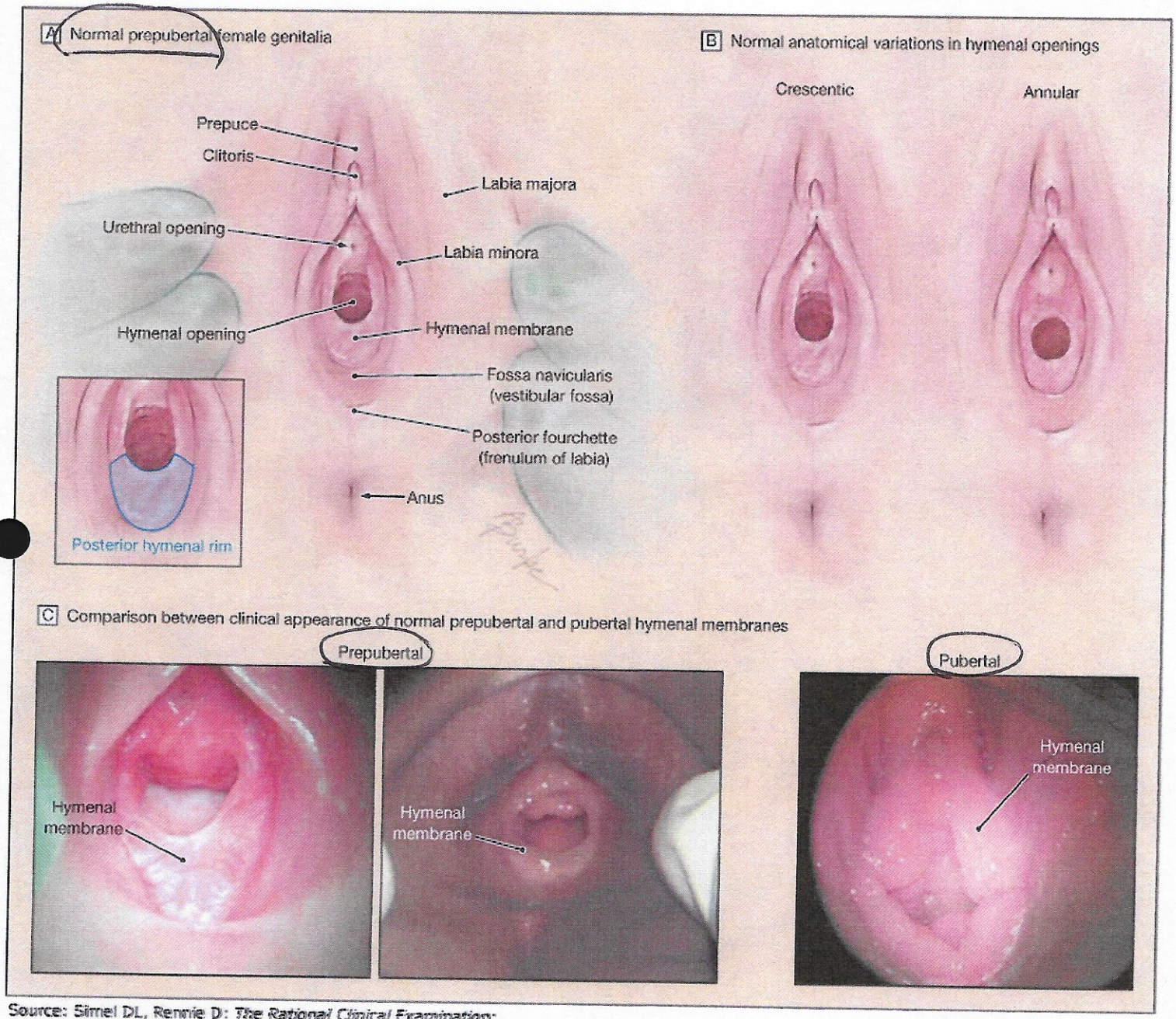
Recognize that it is normal to have normal physical findings.

- most children who have experienced sexual abuse have normal examinations
- Sexual abuse may leave no permanent scars or marks or, if a disclosure was delayed, healing may have occurred
- When examination findings are normal, these findings neither confirm nor rule out abuse. Examiners should note this fact in the child's medical record as well as explain it to caregivers, while reassuring them the child is healthy

Prepubertal positioning



Source: Simel DL, Rennie D: *The Rational Clinical Examination: Evidence-Based Clinical Diagnosis:* http://www.jamaevidence.com



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