BACCH Trainees' National Study Morning Child Sexual Abuse-20260323_095204-Meeting Transcript

23 March 2026, 09:52am

52m 36s

Emma Grindrod started transcription

Anna Riddell 0:12
Yeah, let me.
Yeah.
Yeah, I'm not sure there'll be much of A transcript because most of my slides are pictures. They'll be very, very different to Michelle's talk, which is why I can't really, yeah, it can't be recorded. I'm just going to see if I can share now, see if it works.

HELLIWELL, Emily (SIRONA CARE AND HEALTH) 0:22
OUH.
Yep, that's we totally understand. That's perfect.

Anna Riddell 0:36
SUSSEX.
Uh...
OUH.
Okay, hopefully you are seeing, yeah, the presentation. Okay, and I've got until 10.30, is that right?

HELLIWELL, Emily (SIRONA CARE AND HEALTH) 0:45
That's it.
Yes, please. We're due to have a break. If you run a few minutes over, it doesn't matter at all. Thank you.

Anna Riddell 0:54
Yeah.
Okay, so I have got quite a lot of pictures. So most of the talk will be focused on that. So I'm hoping, although I have got a lot of slides that we'll be able to get through them relatively quickly. I just a bit of a

a health warning, I suppose, for people who maybe haven't seen a lot of this kind of material before. So the pictures are all of genitalia, male and female genitalia of all ages, and there'll be some pictures of injuries. So if there's anybody who
doesn't feel like they want to continue with the training, that's absolutely fine. These sorts of things affect people in different ways. So don't feel it's a problem if you need to duck out for a few minutes for whatever reason. But I'm just letting you know in advance so that you can be prepared.
So I was asked to talk on angiogenital presentations, normal, abnormal anatomy, differentials and mimickers to CSA. And that's kind of, well, the whole of the purple book really to do in about 40 minutes. So the way that I've decided to approach this is really just to
show you lots and lots of different pictures, because I think that's probably what you don't get a chance to see in your practice. I'm sorry, because I don't know much about who is on the call. I'm assuming quite a lot of you are trainees, community specialist trainees, and some of you may have done
some sexual abuse work, but a lot of you probably haven't. So let's launch into it. So this is what I'm going to try and cover. So anogenital anatomy, how to do the actual examination of the anogenital area, what's normal,

HE **HELLIWELL, Emily (SIRONA CARE AND HEALTH)** 2:44
Actually?

AR **Anna Riddell** 2:58
A little bit about some findings in acute and non-recent sexual trauma in girls. And then some conditions that may look a bit like CSA but aren't. And then hopefully if we get time, some **** signs and signs in boys as well. So there's quite a lot to cover. So this is a body map of the female genitalia, not particularly age specific, but probably peri-postpubertal. We might have slightly different body maps for pre-pubertal, but at any rate, there's a list, as you can see, of
anatomical names. And what I'd like you to do, nobody has to shout out, just see, go through that list. I'm going to give you about a minute and see if you think you can correctly identify them. I'm going to give you a diagram in a minute which will tell you the correct.
anatomical structures. So I'll give you a minute to do that now.
Okay, so here are the, oops.

Is it not forwarding? Why is it not going? Oh, there we go. So this is the let them labelled up. I think a lot of you would have got most of them, hopefully. There are some that people do find really tricky. And the ones classically that people get find difficult are posterior forchette. And that is essentially the point, the location where the labium majora meet in the midline here. So it's an actual point, it's not an area. In contrast, this area here,
Fossa navicularis, and that if you translate in this from the Latin, it means boat, and that's kind of what it looks like. So, it's the dip here between the posterior fuschette and the base of the hymen there, and it's like a kind of...
dip or where you may even see fluid collect. So that's more of an area than a point, which is the posterior for shed. Hopefully the rest of it you found relatively straightforward, but it's really important that you do know about the anatomy because as I'm sure you gathered from Michelle's
talk, accurately describing where you see injuries is very important and also then being able to relate that to the body of evidence that we have around them.
So the female genital anatomy does change over time. Under the age of two, often there is maternal oestrogen and that can either be that it's still swimming around after birth or the baby is being breastfed. And the hymen can be quite thick still and folded.
and waxy and opaque in appearance. And then between about two and the onset of puberty, the hymen becomes really thin and vascular and it's almost more like a flat membrane which covers the entrance to the vagina. Looks quite different. Then during puberty, the oestrogen comes back again.
and the hymen thickens and folds. We sometimes call it fimbriated. Fimbriation is like a wiggly edge, a bit like a scrunchie. And the opening increases the size. And although you can't always see the opening, because as it is with a scrunchie, often the folds
cover over the opening and you can't actually see through to the vagina.
So I'm going to start showing you a series of pictures. So this is an infant. And just to locate where we are, that's the hymen here.
This would be the fossa navicularis between here, the base of the hymen, and the posterior forchette, which is here. And then you can see that there is an opening within the hymen, and you can just see into the vagina there. And this would be called an annular.
hymen and you can see that the although there is quite a lot of mascularity there is a

lot it's quite opaque.
So this is pre-pubertal child and we've got two different shapes of hymen here. So this is an annular hymen again. And the reason we call it annular is because it's ring-like and there is some hymen present here anteriorly. So this is anterior, this is posterior.
Again, posterior forechette, you can see the dip into the fossa navicularis here, and you can't actually see the base of the hymen because it's hidden because of the position of the photograph. In this picture, this is a crescenteric hymen, and the reason for that is that you've got this crescent shape.
Again, the orientation, posterior forchette, can't really see the fossa navicularis. These are the labia minora and they're tiny because this is a pre-pubertal child. ******** is under here and this is the urethral opening.
And with the crescenteric hymen, there is no hymen here. So that is the anterior vaginal wall there, which you can just see through the opening. But there's no hymen. And that's why it looks crescenteric. And that is completely normal. That's a normal variant.
So then as the child gets older, oestrogen starts to come on board gradually over the period of puberty. And you can see here, there's an annular hymen and you can see that although the hymen is still fairly flat,
in appearance and not folded, it is starting to look more opaque and thicker.
And then even further on, and you can see this child is in puberty because there's some pubic hair here.
there's some discharge present and you can just start to see the hymen a lot thicker and the onset of these folds which give an irregular edge. So that is a normal appearance. That irregularity is not because there have been defects or injuries in the past which have healed.
That's because the hymen is folding over on itself.
I'm hoping that you're orientated now, so I'm not going to give you those anatomical landmarks. I'm hoping that you'll be able to work it out, even though these pictures are quite close up, it can be a bit difficult. So
puberty, onset of puberty and after puberty is finished, this is classically what you see. Now this would have been a crescenteric hymen because there's really no hymen present here at all. And here is the anterior vaginal wall sitting behind. But you can really start to see these folds and
This is where it can get really tricky to identify if there are any defects. And I'll show

you some techniques later, which we need to use in order to clarify. If you just took this at face value, you might think that that's a deep notch here. But in post-pubertal children, girls, you need to be
much clearer by using other techniques. And this is another hymen, which is really, I mean, you can see well into the vagina here. You can see the posterior vaginal wall and the anterior vaginal wall. And you can see normal white discharge here in the vagina.
And here is the hymen, sorry it's got chopped off at the top, but this gives you an idea about the thickening and how hymens can look really different between different girls.
So a little bit of notes about how we do the examination. So in younger girls, we usually use a frog leg position, which we can also call supine. And here it is. I hope you can see that. So the girl, the
the legs are, the knees are bent and the legs are abducted and either the feet are apart or you can actually have them together. Sometimes that helps because it can be quite difficult maintaining this position, although younger children find it a bit easier.
And then if the child is really upset and doesn't want to be lying on a bed, we can essentially have the same position with them sitting on a carer's lap in that way. So we have a look and we look at the external genitalia for erythema, bruises, abrasions, lacerations, which those terms you will have heard.
in the Purple Book talk with Michelle. And then the techniques that we use to identify the structures are these two techniques here, labial separation and labial traction. So separation is you take the labia majora
and you often use your thumbs just gently rested on the labia majora, and you just pull apart gently to separate the majora away from the introitus structures, just to have a look and look at the vestibule and the hymenal orifice.
And sometimes that's enough and you can see exactly what you need to see with that.
mechanism, but often it's not, and you have to use labial traction. So traction is a bit different. You actually have to grip the labia majora between your thumb and forefinger, and you pull them down and out. So towards the child's feet,
and slightly backwards towards the couch. And what that does is it opens up a structure which is obviously 3D. It's not 2D like we see in the pictures and allows a better view to see the other structures that we want to have a look at.

So the urethra, periurethral support ligaments, and the hymen, and sometimes the vagina.
So, those are the two techniques that we tend to use in younger girls.
I'm sorry this is a bit fuzzy, but it gives you a bit of an idea about labial traction and the fact that you've really got to grip the majora if you can between your finger and thumb on both sides.
Another manoeuvre that we can use to help visualise in particular hymen is the prone or knee chest position. And what this does is it allows relaxation of the pelvic floor muscles down and you can see much better into the posterior hymen. And for reasons you'll find out,
in a bit, it's quite important to be able to assess fully the posterior rim of the hymen in pre-pubertal girls.
Just note that we don't use other techniques in pre-puberty. So the other techniques, we might have access to a cotton wool swab to just run around the rim of the hymen to identify possible defects and a Foley Catherine. I'll show you those in the picture shortly.
And just think about why that might not be. Is anybody willing to just shout out why you might not do that?
Or put in the chat, maybe.

TJ **Thompson, Jessica** 16:30
It's painful.

AR **Anna Riddell** 16:31
Yeah, so absolutely. The structures, particularly in pre-puberty girls, are just really sensitive. And if you go anywhere near them with an instrument, they'll probably jump off the couch. So that's why we don't do it.
So this is just an example of frog leg versus knee chest. So I will orientate you here. So this is a pre-pubertal child and you've got the labia minora here, little ones. And here is the posterior falchette and you can see the hymen here and it is actually slightly thickened.
And you can't quite see the fossa navicularis here. So although you're probably fairly convinced that there is a decent width of hymen here, you can't be absolutely sure.
So if you do the prone position with them on their front, so you've now got an upside down

reverse of the clock and you've got labia minora here and here is the posterior forchette. And the hymen drops down like that and now you can see the rim really beautifully and you can see it's a nice smooth curve. Here you might have thought, is there a defect there? Is there one here?
Here it's flattened out and you can see that's actually quite a nice demonstration of what we call a bump, which is caused by vaginal ridge behind and that's completely normal.
So that's those two techniques. So moving on to pubertal girls, as we've already shown, the hymen thickens, enlargens and becomes more elastic and stretchy and less sensitive. There's lots of overlapping redundant tissue. And thinking about that scrunchy analogy will help you understand that.
So often separation traction is just not enough to demonstrate the hymal edge fully. And sorry, that should read lacerations may be hidden in the folds. We don't use the term tears anymore.
So there are two techniques to try and identify anatomy better and that's a moist and sterile cotton swab and you sweep that round the hymenal edge searching for hidden lacerations or defects such as notches or transections. And A Foley catheter is another technique and it's actually
probably better than a swab. Sometimes girls won't tolerate a Foley catheter, although it's not painful, it's just a slightly odd sensation rather than like of pressure rather than any pain. But it is the best way to have a look for these defects. So Here's use of a swab and probably what's been looked at here potentially is a defect here at the 9 or 10 o'clock position. I'll show you a clock face in a minute. And you're just literally putting the swab behind and sweeping around.
to see if you can cheque and tease out any defects that you might see.
And this is a Foley catheter. So you put the catheter in, you can blow it up either with water or air. Some people don't like water because it can give this light reflection depending on your COB scope, which can be quite distorting for the images.
In this case, what we've got is a pubertal girl, and what is being demonstrated here, you can see the erythema and the raw edge. This is an acute laceration, which has occurred in an acute sexual assault. And this Foley catheter is beautifully demonstrating.
that area, which probably would have been hidden in folds without the use of the catheter.
When you do these examinations, it's really important to record accurately what you

see. And this again plays into the Purple Book talk you've just had. So you describe what did you see and that
is use anatomical and correct pathophysiological terms such as erythema, abrasion, laceration, and you use consistent terms to describe those. You describe the examination position you use, and that's very important because that
directly relates back to the evidence base that you are drawing on. So the papers that have provided the evidence in the purple book, they will have, the findings will have been described in particular set positions that I've just talked about. Make sure you talk about the examining.
examination technique used, any instruments. And we always use body maps as well as colposcopy. Colposcopy, which is the use of a video camera to take still and moving images, is increasingly relied upon and pretty important in court.
And some of you will have been to peer review where we look at these images for quality assurance purposes. But it is really important still to do a body map. This is a body map that I did quite a number of years ago. So it's using terms which are a bit old, which I would not use now, such as tear, for example, here.
but I'm really just putting it in to give you an example of what a drawing might look like. So here we've got the bigger picture of the buttocks, thighs and genitalia. And there what this represents is a much more detailed drawing of the actual hymen. So we have the hymen tissue around here,
What I've tried to show is defects within the hymen and then these petechiae, which are on the anterior vaginal wall. It doesn't matter if you're not that great at drawing. I'm not particularly great at it. But what this does is it gives really quite a good idea of what the findings were for other people to cheque and interpret and quite useful alongside the colposcopy.
I'm not going to go through this in detail because Michelle's just given you this talk, but really these are, this is the sort of list of kind of findings that you might be looking for. And these are the correct terms that you should be using.
This is, we don't, there's no image for the current edition of the Purple Book, because it's all online. But if you ever got a physical copy of the old editions, it looked like this, which is why it's called the Purple Book. And this is the clock face that we use to describe the location of the findings. It seems like it's pretty intuitive this, but actually people do get really confused about this. So 12 is anterior, 6 is posterior, and it's the same for the ****. So just superimpose the **** here.
We've got anterior, posterior, and we use these clock faces to describe the exact

location of what we're seeing.
So I'm just going to go through a few normals and then a few other pictures. I'm going to, I'm not going to test you on these because I don't think that's particularly helpful in this kind of forum. But if anybody wants to ask me questions or query, to cheque your understanding of what I'm trying to describe, just do **** in.
So, prepubertal hymnal variants, so these are normal.
Here we go again, a crescentic hymen with no hymenal tissue anteriorly. And here we've got a collar hymen, or sometimes they call it a sleeve hymen, where the hymen is projecting out in a 3D way. And you can see there's a rim.
So it's not always flat. And we've got an annular hymen, which is starting to fold and thicken here with a perfect annular defect in the middle, which is normal. And here we have a septate hymen. So sometimes in normal,
development, the hymenal separation, which happens, leaves this remnant here, which connects the two sides of the hymen. And you can just see, here it is, there's a septum. So it almost looks like there are two holes here in the hymen.
And there are, but in most cases, there is a single vagina behind. What you do have to think about when you see a septic hymen, if it's associated with other problems, is whether there could be a
bicorneurate vagina or uterus. So that's something you might want to consider because it's essentially there because of part of the normal development.
That's just a much bigger picture of a crescenteric hymen, perhaps easier to see. There's no hymen here at all, and we've just got a continuum here to the anterior vaginal wall.
And here we have a much larger picture of annular hymen. And it's not a perfect ring-like hole here, but this is normal. There is this is the normal width of the hymen all the way around.
This is another normal hymen and you might look at that and think, what about all these defects here? Are these defects or are they part of the normal folding? This is a normal hymen and again, really good posterior width here. Looks a bit translucent.
in this part and are very, very thickened in other parts. So it's in the process of puberty happening. And you can see the ridges here of the vagina wall behind. You would not use a...
swab in this child because she's too young. You could potentially do a bit of irrigation. If sometimes what happens is when you first do your separation and traction, all of these edges are slightly stuck together with the secretions and won't

separate. And if you put a little bit of irrigation with some water, which a lot of pre-puberty girls will tolerate, as long as you give them warning and tell them it's going to be a little bit cold and wet, that can allow these edges to separate so you can view them. This would be a good
case to do a prone position and see if these anterior structures drop forward so you can see the edges a bit more clearly.
This is a normal Easter giant, Easter nice hymen and a 12 year old girl.
This is annually. You can see that there is hymen all the way around, and actually there's really quite a lot of hymen here posteriorly. This is the base of the hymen at the bottom. That's the posterior forchette. And this is quite a nice demonstration of the fossa navicularis here, that kind of
boat-shaped depression.
Sometimes when you have a look, depending on the position the child is in, this child, probably the pelvis is tilted quite a bit upwards. So you're really, you can't see the fossa navicularis at all here. And you can't even really see the base of the hymen. Here's the posterior forchette.
And this can be a bit confusing because you're thinking, oh, is this hymen? What's going on here? In fact, this is the urethral orifice here, and these are the periurethral bands which are holding the urethra in place. And either side, there is a depression. So that's again why it's really important to cheque your anatomy. We had a case in the SARC recently where this appearance almost looked like a septate hymen, but in fact it was just the view of the images and
the slight variation of anatomy in that particular child. So that's where experience comes in and just making sure that you're clear about where structures are.
Here's another septate hymen. And again, you can see where the connexion is being maintained and the remnants here and two holes either side. And you can see the vagina quite nicely behind there.
I'm just going to cheque time, how we're doing. Okay. This is a condition that a lot of you will have seen. So in fact, there's hymen there, hymen here. Sorry, labium, this is the labium minora here. And the labia minora have fused
together. And this can often happen due to ***** vaginitis, inflammation, infection in young girls. And it can be quite confusing because you can't see the structures behind. I'm not going to talk about treatments particularly for this, but it is a really common
normal variant and it does resolve with age. So when you get to puberty, the

oestrogen means that this is very less likely to happen and the structures all open out. Here are two pictures of ***** vaginitis.
which again is a really common condition. This is in a slightly younger child with early redness and glistening wet skin and really, really quite sore here. You can see the hymen here. And here there's a chronic vulvaginitis and the skin has started to thicken.
and break up and you can get a bit of bleeding when this happens and it can be one of the reasons for presentation of blood in the knickers to consider.
So now we're starting to get into some pictures of abnormal findings, which you may need to interpret. So here's a two-year-old and this is bruising on the hymen. The hymen is still thickened and folded. Here is the orifice, the hymenal orifice here.
which may be a bit tricky to identify. And you've got bruised areas here.
So I describe as between 9:00 and about 4:00. And there's actually some bruising here and some tiny particular bruising here as well.
So you might want to consider why that bruising has happened and you will have to relate that to the evidence behind bruising and hymens from the Purple Book in that it's really uncommon outside of sexual abuse because these areas are very highly protected.
By the labia majora and labia minora.
And then you may want to relate it to the reason for this child presenting. Is this a presentation where there is a high level of concern about sexual abuse or is it a presentation where there is no concern and there may be some, possibly some other explanation which you need to consider?
Here is a seven-year old who has very accurately described and had witnessed A straddle injury. So you're clear that this is not sexual abuse because the incident has been witnessed and the timing is consistent with the findings. So I'm sorry because the picture is not that clear, but here we have
tiny little labia majora here, which meet here at the posterior forchette. And we have an abrasion here at the posterior forchette where the surface of the skin has been rubbed away. That's what an abrasion is, as opposed to erythema where the surface of the
skin is intact and you have a redness underneath or a bruise where you have the blood vessels bursting, but you have intact skin. This could even possibly be a laceration. Not absolutely clear from this picture, but you can very clearly see the bruising here.

And that is.
Bruising in the labia.
Menora, sorry. This is the labia majority here, and there's also some bruising here on the labia.
Labium minus on the left.
So quite a lot of injuries to describe here, but this is completely consistent with the mechanism described.
Here's a picture of what we are looking for, essentially, when we're doing the prone position.
to look at the posterior hymenal rim. So we can see very clear view here into the posterior vagina, vaginal wall, and here's the anterior vagina. And really the hymen is limited. I'm sorry because the quality of the picture isn't great, but you can see the hymen rim is limited
to a tiny, tiny width. And really, there's very little distance between the fossa navicular iris and there's very little remnant here.
It's the theory here is that this is chronic sexual abuse and that the hymen has been rubbed away as a result of that and that's why you don't see it. We also have some what we call friability here in the posterior forchette.
which again could be consistent with chronic sexual abuse.
Again, this is a prepuversal girl and what's being described here, we have an annular hymen, but we have quite a significant defect here. And this is a pretty good view. You can see the posterior hymenal width is good, but there is a defect here. And I think we would describe that as a notch.
And because of the degree of irregularity, we might assume that the normal orifice probably sits here where I've got my cursor, and therefore this notch is more than 50% of the width of the hymen at this point.
and we would describe that as a deep notch.
So this is a bump at 3:00. The bump is created by vaginal ridge and is not of any significance. But the deep notch, if you look up in the purple book, there is quite an evidence base behind that. For those of you that have done a bit of this work before, you might say,
Well...
Isn't it the case that the only evidence base behind deep notches is those sitting posterior to the 9 to 3:00 position and this notch is in about the 1 to 2:00 position.
And I think that's definitely something that you would need to comment on when

you're
Talking about the finding in your witness statement, but you would still...
describe what you see and put in place the evidence base that you have available to you and also then contextualise it with the history that you have about the possible sexual abuse which has occurred. These are two pictures, same child,
So there's an acute injury and a healed injury, acute injury on the left, healed injury on the right. This was an acute sexual assault of a pre-pubertal girl and she sustained A laceration, which you can see it. It's not entirely clear because there's a fair amount of
blood here, but you can see there's a lot of bleeding. That's the anterior vaginal wall, that's the posterior vaginal wall, and there is a laceration here. There's also some injuries here on the perineum, just below the
posterior forchette. And then this child was seen a week later. And what is, you can still see some erythema on the hymenal edge here, but you can see that there is what we call a transection. And A transection is a complete defect of the hymen down to the base.
of the rim. And A transection is a very significant injury and is highly suggestive of sexual abuse or sexual assault. In this case, because we have a healing picture, it really helps us to understand what happens when these injuries heal. And you might be surprised
how quickly this healing has occurred, one week. But you can get healing in less than three days. So it's really important to see these injuries as soon as you can after the incident has happened. Here are a few mimickers, oh, sorry, of sexual abuse. So Lichen sclerosus, some of you will have seen this. It's an inflammatory condition of unknown origin. You get this pallor in a figure of eight pattern around the genitalia and the **** area. And quite often what looks like bruising, which is in fact blood vessels below the skin, which are inflamed.
and you can get bleeding. So this again can be a cause of blood in the knickers and usually really easy to identify on examination.
Here we have a urethral prolapse and you might say, oh my goodness, I can't see anything there. It's just a black hole. Well, this is a swollen urethra, which is taking up the whole of the vestibule practically. It's in a donut shape and usually very dark red because it's full of
clotted blood. So that again is something that if you've seen it before, you will always recognise. And another cause of bleeding in the knickers in pre-butal girls.

Here we have a normal variant, a hemangioma.
which may be mistaken for bruising. And this is going back to that picture that I described with the periurethral bands here. And this is a dilated urethra, which some people may mistake depending on the position of the examination for the hymen.
Um, Janice Wartz, so...
These are gentle warts. This is anterior, posterior. This is pubertal girl, and that's the hymal ridge. And what's interesting here is you can see that they look really different on the different epithelial tissue here. So the epithelium changes from squamous to columnar epithelium and warts look very, very different. So just be aware of that when you're examining the genitalia of girls. I'm not going to show a gentle, an **** warts picture, but essentially they look like that around the ****.
Okay, how am I doing for time? Oh, I've gone over badly. What do you want me to do, Emily, because I've got perianal and boys left.

HE **HELLIWELL, Emily (SIRONA CARE AND HEALTH)** 41:56
Oh, it's so difficult. It's really interesting, so I really don't really want to stop you.

AR **Anna Riddell** 42:04
Then, but not anywhere near as long, but I probably need another 5, maybe, yeah, 5 minutes.

HE **HELLIWELL, Emily (SIRONA CARE AND HEALTH)** 42:10
I think that we should carry on if people feel like they need to step out for their break. But personally, I think that we should carry on. Yeah, getting a thumbs up. Yes, please continue. Yeah. Thank you. Keep going. People are saying agreed. Keep going. Thumbs up. Thank you, Anna.

AR **Anna Riddell** 42:17
Okay, yeah, so people can choose, they can choose where they want to stay or not. Sounds good.
Okay, so examination of the **** area, left lateral position, it has to be that because for consistency of description and use of evidence base. But also, if you think about it, if the child's lying on the left, then the ****** is dependent. And
That allows you to have a really good view into the **** area. We can again do the knee chest position in young children if they won't tolerate lying on a couch. We

simply separate the buttocks using the palms of both hands, not too much because otherwise you might distort it.
and you're looking for tone and you're looking for all the same things that we're really looking when we're looking at the genitalia. In addition, we've got venous congestion, I'll show you a picture, and prominent veins. Scar tissue is important, but we very, very rarely see that. Often see skin tags and
possibly in the Association of Constipation. We use the word laceration and not fissure, which is a very surgical term. And we're also looking for **** dilatation.
So I am just going to very quickly tell you about these red areas. So in terms of dilatation, where there are two types of dynamic and static. Static is found really only in children who have spinal cord abnormalities. So that's not common. Dynamic is basically when you
separate the buttocks, the **** is closed to start with and then opens up over a period of time. We don't examine for more than 30 seconds because then you can have a bias in the examination. If when you do that, you can see all the way into the ******, that's described as total dynamic dilatation.
If you can only see into the **** canal, then it's external.
Obviously, if you're worried about any injuries further up, then with children, you're going to have to get help to look for those. This is just to tell you, show you what you would be looking at. So with dynamic, really, you're only seeing into here, you might see disjunction, but with total, you can see right into the ******.
And this is the anatomy where you to describe where your findings are. This has changed in the new purple book. So the verge is literally where the folds meet and the **** opening and the margin is where the folds are disappear into the skin of buttock.
So that's normal. So here's the verge. Here is the margin, just about. Here we've got a median raif in a boy, which is quite prominent. That's normal. And again, here's the verge. Here's the margin. Here we've got a nine-year-old boy with a lot of redness. I suppose you want to know why that is.
And we have some prominent vein here. Probably wouldn't describe that as venous congestion, but there is definitely a vein. And then you need to cheque for the regularity of these folds. This is essentially normal.
This is not normal. So this is very irregular. We've got a deep healed laceration here. And you can see the mucosa in the ****. So this would be, and this is dilated. So this would be external **** dilatation and there's a tag there.

This is venous congestion and typically it would be a ring in the **** margin here and we've got a little tag there, but the verge actually looks normal.
So that's **** in an absolute rush. And here we've got male genitalia, which are actually much easier because there's less to interpret. You just need to look very carefully and lift the penis up and look underneath the ventral.
ventral side of the shaft to make sure you don't miss any injuries and make sure that you also cheque underneath the scrotum for injuries. Often you will have to retract a foreskin to cheque for frenulum injuries. Just be careful in pre-pubertal boys because As you all know, they don't all retract. Sometimes it's good to actually ask the child to do to retract the foreskin themselves.
This is in anatomy much, much simpler. And you all know about the changes in puberty.
So some injuries here, we've got an acute laceration, you can see it's still bleeding. This is the dorsal aspect of the shaft. That's what you've described. And there's also quite a lot of inflammation and erythema here in the creases and by the looks of it between the buttocks.
Um...
Here we have a bruise on the left lateral area of the shaft. And you would want to cheque underneath and retract the foreskin if you could, to see if there's any injury of the glands, which you can just see as a shape here behind the foreskin.
This is a hemangioma, so somebody might mistake that as bruising, but it's not. It's A resolving hemangioma with normal genitalia.
So take home points. Just remember, gentle examination may trigger memories of the abusive events. So you have to be very sensitive how you approach it. They may actually disclose what's happened while you're examining them. And sometimes you do need to just ask clarification questions to allow you to look at the right things.
If you do find anything, take the time to explain what you found and significance, don't avoid that. It's really important that we're open and honest about findings, but reassure them because the great majority of injuries do not cause any long-term impacts.
And that can be that can be an incredibly powerful therapeutic intervention for the child. Always remember the examination is most likely to be normal in the great majority of cases. This is because the nature of abuse, often particularly in children doesn't cause damage. The vaginal opening can be very elastic in post-pubertal children, girls.

and may not be damaged during sex.
and healing can be very rapid and can be complete without any trace. So apologies for going over. I've stopped sharing.

HE **HELLIWELL, Emily (SIRONA CARE AND HEALTH)** 49:44
I know I can say on behalf of all of us, no need to apologise. That was an absolutely fantastic talk. Thank you. It would take years for us to be able to get anywhere near as experienced and kind of seeing all those images as difficult as it is, is incredibly helpful. So thank you so, so much. And I think you were correct to do lots of images. I think that's an excellent way for us to

AR **Anna Riddell** 49:47
OUH.

HE **HELLIWELL, Emily (SIRONA CARE AND HEALTH)** 50:08
to kind of learn and get orientated. Does anybody have any questions for Anna? Yeah, please, Rachel, go ahead.

PR **POWELL, Rachel (BARNSLEY HOSPITAL NHS FOUNDATION TRUST)** 50:20
Oh, thank you so much, Anna, for a fantastic presentation. I just had a sort of logistics question, if that's okay, which is normally when I'm doing child protection medicals for the body maps, I like to literally have the paperwork right next to me, next to the injury, so that I can kind of get sort of get it in the right place because I find that if I don't, I end up drawing it in the wrong place. Like I feel like, whereas

HE **HELLIWELL, Emily (SIRONA CARE AND HEALTH)** 50:23
Okay.

AR **Anna Riddell** 50:26
Mm.

HE **HELLIWELL, Emily (SIRONA CARE AND HEALTH)** 50:38
Yeah.

PR **POWELL, Rachel (BARNSLEY HOSPITAL NHS FOUNDATION TRUST)** 50:39

I feel like that's going to be really difficult for these because you can't kind of have somebody holding all of it open while you're drawing it on the body mat. When do you do that? Like, do you do it from the photographs or do you just get better at remembering what it looked like?

AR **Anna Riddell** 50:45
Yeah.
Yeah, I mean, I think in reality, it can be really difficult to do these examinations single handed, although we try to do that mostly because we don't want many people in the room. It just takes a bit of expertise. But me personally, I will never do an examination like this without a cop scope.
And I work in an environment where I have where I have access to a coposcope. So what I do is I visually cheque because what you're looking at on a coposcope is still a 2D image. And what you see with your eyes is a 3D image. So the body map is actually quite a good way of

PR **POWELL, Rachel (BARNSLEY HOSPITAL NHS FOUNDATION TRUST)** 51:11
Yeah.
Yes.

AR **Anna Riddell** 51:31
noting the difference between those two things as a cross check. But to be fair, I have both. I have body maps and colposcopy.

PR **POWELL, Rachel (BARNSLEY HOSPITAL NHS FOUNDATION TRUST)** 51:41
And is it okay to kind of do the body map after the, like do it from the colposcopy? So, okay.

AR **Anna Riddell** 51:45
Yeah, I often do that. I go back to the Copscope images and just straight afterwards and just try and annotate the body map to give the 3D impression, which can be things, for example, edema. So edoema you cannot see on a 2D image.

PR **POWELL, Rachel (BARNSLEY HOSPITAL NHS FOUNDATION TRUST)** 51:59
Right.

AR **Anna Riddell** 52:05
It's a 3D thing, but you might want to comment, say, well, I did actually see edoema with my eyes. And you might want to annotate the body map to say that.

PR **POWELL, Rachel (BARNSLEY HOSPITAL NHS FOUNDATION TRUST)** 52:14
Great. Thank you so much. That's really helpful.

AR **Anna Riddell** 52:16
Yeah.

HE **HELLIWELL, Emily (SIRONA CARE AND HEALTH)** 52:18
Okay.

Emma Grindrod stopped transcription