The Royal Australasian College of Physicians

Paediatrics & Child Health Division

Genital Examinations in Girls and Young Women: A Clinical Practice Guideline

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1. Purpose of this Clinical Practice Guideline

The purpose of this clinical practice guideline is to guide medical practitioners and nurses in relation to the indications for, and the conduct of, genital examinations in girls and young women.

This guideline may be of interest to all health professionals who conduct genital examinations on girls and young women.

This guideline does not specifically refer to examination of the anal region. It should be noted, however, that examination of the perineum and anal region is usually appropriate when girls and young women are examined because of suspected genital inflammation, infection or assault.

2. Governing Principles

The girl's or young woman's best interests (their physical and psychological health and wellbeing) are paramount and should guide all decision making.

Best practice includes effective communication. Doctors should take the utmost care in explaining the procedure(s) to the girl or young woman (and parent/guardian).

Examinations of girls' genitalia should be conducted so as to minimise discomfort and distress. Care should be afforded to avoid unnecessarily touching the hymen of prepubertal girls because this might cause pain or discomfort.

Genital examinations under anaesthetic, transvaginal ultrasound scans and evaluations for suspected sexual assault should be performed only by doctors who have satisfactorily completed relevant training[1] and doctors who are under supervision.

3. Indications for a genital examination

Inspection of the genital area of girls and young women is commonly required as part of good medical practice. Indications include (but are not restricted to) the examination of newborn female babies, skin rashes in the genital area, urinary tract infection, enuresis, herniae and symptoms affecting the genital area.

A genital examination might be indicated for:

- Sexually transmitted infection
- Pregnancy
- Pelvic pain or other genital symptoms or concerns
- Sexual assault
- Pap smears, in accordance with national guidelines.

[1] The writing group respectfully recognises the role of the colleges in determining curricula, approving training pathways and certifying successful completion of training for each professional group.

- Foreign body

The decision to perform a genital examination is the responsibility of the examining doctor and is based on

a) appropriate medical indications (including forensic medical indications),
b) willingness of child and/or parent/guardian and
c) circumstances of the presentation (time, pain etc).

A genital examination should not be conducted without addressing these criteria.

4. Examiner / personnel

Genital examinations should be performed by appropriately trained and experienced medical practitioners. In particular, examinations under anaesthetic, trans-vaginal ultrasound scans and evaluations for suspected sexual assault should only be performed by doctors who have satisfactorily completed relevant training and doctors who are under supervision.

In clinical practice, there is often pressure from parents and referring child protection workers to provide a doctor of the same gender as the child. In the context of sexual abuse the limited literature available suggests that for children the kindness of the doctor is more important than gender[1].

An appropriate adult witness, support person or chaperone should be present when examining a child. Many children prefer the support of a trusted family member or close friend. Other personnel who might be appropriate include: medical, nursing/allied health staff, interpreters, culturally congruent persons or caseworkers (for intellectually impaired patients). When examining a young woman, the presence of either a trusted family member, support person or chaperone should be encouraged and available, respectful of the young woman's right to decline their presence and the doctor’s right to decline proceeding with an examination in their absence should they deem it appropriate. This practice provides a level of security for children and young women, as well as the doctor. It is imperative that the child's/young woman's dignity and privacy be maintained throughout the examination, regardless of the presence of others.

Doctors should inform and familiarise themselves with any tests that need to be performed, the equipment required and methods of sampling for investigation prior to commencing the examination.

5. Consent

Doctors need to ensure valid consent from a young person and/or their parent or guardian prior to conducting a genital examination. Valid consent must be voluntary, informed and based on the capacity of the patient to consent. Doctors should familiarise themselves with relevant

state/territory legislation regarding capacity to consent. Capacity to consent should be considered on an individual basis and is not solely related to age. Children can consent as long as they have the capacity to understand the information and the implications of the procedure to which they are consenting.[2]

When parents or guardians have consented on a girl's behalf, doctors should take the utmost care in explaining the procedure(s) and proceed only with the girl/young person's assent.

Special consideration needs to be given to obtaining consent from patients who are:

- Intellectually impaired
- Mentally ill
- Physically impaired
- Drug or alcohol affected
- Non-English speaking background
- Injured, pain, shock
- Sleep deprived
- Unable to give valid consent

Except in a medical emergency, genital examination should not proceed in the absence of valid consent.

6. Confidentiality

If the girl or young person has the capacity to consent then she is also capable of forming a relationship of confidence and should be given the opportunity to talk privately with the doctor. The doctor should indicate to the child or young woman that confidentiality can not be guaranteed in the following circumstances:

- Risk of serious harm to self or others
- Suicidal ideation
- Serious criminal activity
- Psychosis
- Sexual or physical abuse

7. Explanation of Findings to the Child and Parents

Care should be given to explaining the examination findings to the girl / young woman. Explanations need to be tailored to the girl's/young woman's level of comprehension and reassurance given where appropriate.

In circumstances when the parent or guardian is providing consent to the examination of a girl/young woman, or when the girl/young woman consents to the sharing of information, an explanation of the examination findings should be provided by the examining doctor during the consultation.

8. Factors that Influence the Conduct of Genital Examinations

8.1 Age

In babies and toddlers genital inspection is often an important aspect of the general medical examination.

Digital or instrumental vaginal examination is very rarely indicated in prepubertal girls. Allegations of sexual abuse, vaginal bleeding, vaginal discharge or suspected genital malformation may require visual inspection of the vaginal vestibule and/or ultrasound examination. If this does not reveal the required information and further examination is deemed medically necessary, then examination under anaesthesia by appropriately trained medical practitioners may be indicated.

In a pubescent or postpubertal girl, digital or instrumental examinations of the genitalia should only be performed with informed assent from the girl and the consent of their parent/guardian or with a mature minor's consent. Privacy and confidentiality are of the utmost importance in dealing with this group. Components of the examination and findings (normal and abnormal) must be communicated to the patient at her level of comprehension.

8.2 Prior Sexual Experience

If a girl/young woman states that she is NOT sexually active, digital or instrumental vaginal examination is unlikely to be warranted.

If a visual inspection of the vaginal vestibule does not reveal the required information and further examination is deemed medically necessary, then an instrumental examination may be performed (with anaesthesia if necessary) by a trained and experienced medical practitioner.

Doctors should be aware that a significant proportion of young people under 16 years of age report having had sexual intercourse[3]. The possibility that this was non-consensual and occurred in the context of child sexual abuse should be considered. The legislation may vary between Australian states/territories and New Zealand and medical practitioners must be familiar with their local legislative and policy requirements in managing suspected cases of child sexual assault. If in doubt consult with the local sexual assault/child sexual assault services.

8.3 Suspected or Alleged Sexual Assault

When sexual assault is suspected (history from the patient, family/friends, police or clinically) a genital examination may be indicated and should be conducted by a practitioner with specific training. Doctors performing examinations for suspected sexual abuse must act in accordance with regional policies, procedures and practices and in accordance with local government legislation.

Unless there is a medical emergency, best practice principles indicate that the girl or young woman should have a single examination.

Medical care should be provided in an holistic manner that addresses the girl's or young woman's psychological needs and provides for her continuing health and well being. In many centres this care is provided by a multidisciplinary team.

When sexual assault is alleged to have occurred within the previous 72 hours the girl or young woman should promptly be offered a comprehensive forensic medical evaluation, including genital examination.

When sexual assault is alleged to have occurred more than 72 hours previously, the girl or young woman should be offered an appointment for a medical evaluation to assess her general health and well being. A genital examination may form part of that assessment.

Photo-documentation of genital examination findings is regarded as 'best practice'.[4, 5, 6] Video-colposcopic documentation is regarded as superior to still photography. Consent for photo-documentation should be obtained prior to the procedure. Adequate security for the photo-documents must be ensured and maintained.

Photo-documentation might reasonably be viewed by suitably qualified medical professionals in order to provide a second opinion about examination findings. However, photo-documentation should not be released for viewing by members of the public (including jurors and legal professionals).

9. Vaginal instrumentation and medication

9.1 Speculum Examination

The indications for speculum examination include:-

Pap smear
Endocervical swab for investigation of possible infection
Endocervical swab for forensic investigation
Assessment for abnormal per vaginal bleeding
Assessment for possible intra-vaginal foreign body.

9.2 Examination Under Anaesthetic

Examination under anaesthesia (EUA) should only be undertaken when information being sought cannot be obtained by examination of the conscious girl/young person and valid consent has been obtained.

Doctors must ensure that adequate equipment appropriate for the size / age of the girl/young woman is available. This might include a nasal speculum, hysteroscope (for use in the vagina), narrow speculum(rather than the usual adult size) and adequate lighting. Doctors undertaking the EUA should have adequate knowledge to allow recognition and interpretation of the findings / pathology in girls and young women.

9.3 Per Vaginal medications

The use of vaginal pessaries in girls as a means of administering medications is not appropriate. This applies to prepubertal girls as well as young adolescent women.

9.4 Trans-vaginal ultrasound scan

Trans-vaginal ultrasound is a non-ionizing radiologic investigation that is used in conjunction with trans-abdominal imaging to obtain more accurate visualisation of the pelvic organs. It should only be performed when the patient has given informed consent. It may be appropriate for some sexually active girls. Consideration should be given to the presence of a support person and/or chaperone.

Guidelines for the performance of such an examination and gynaecologic examinations are provided in the ASUM policy manual with specific reference to ASUM Policy C3, Policy on Vaginal Scanning by Sonographers and Policy D8, Guidelines For Performance of a Gynaecologic Scan.[7]

10. Changes to Appearance of Genitalia

Any alteration to the appearance of genitalia that occurs as a result of examination should be documented and the girl and her parents/guardians informed.

Appendix 2. Suspected Sexually Transmissible Infections

A. 2.1 Investigations for STI pre and post puberty[8, 9]

The anatomy, physiology and normal flora of the prepubertal genitalia, particularly the vagina, differs from post pubertal genitalia.

Non-specific vulvovaginits is the commonest cause of genital discomfort and or a vaginal discharge in a prepubertal child. The vaginal discharge is usually watery and often associated with an oval area of erythema (inflammation) around the labia majora. Swabbing is not indicated as part of initial management and may cause unnecessary discomfort to the child. Any results should be interpreted with an understanding of the normal flora seen in the vagina in this age-group. Microbiological screening should be considered if the discharge is purulent, if the girl has a vaginal discharge and appears systemically unwell or if usual measures to resolve the symptoms have failed and the reported amount of discharge remains significant.

In postpubertal young women Chlamydia trachomatis and Neisseria gonorrhoeae typically infect the columnar epithelium of the cervix but prior to puberty these organisms infect the vaginal epithelium. Therefore, in prepubertal females an endocervical swab is not necessary to detect these pathogens[2]. (In girls and young women of all ages these organisms can infect the urethra, anus, throat and conjunctiva. Consideration should be given to also collecting swabs from these sites.) Trichomonas vaginalis can infect the vaginal epithelium in children as well as adults. Bacteria such as streptococcus, staphylococcus and E.coli can cause symptomatic infection in prepubertal vagina. Candida species are unlikely pathogens past the early neonatal period and prior to puberty because they favour an oestrogen rich environment for growth.

Nucleic acid amplification (NAA) such as PCR employed on a first void urine specimen or blind vaginal swab can detect *C.trachomatis and N.gonorrhoeae* in girls and young women. The first void urine specimen has the potential advantage of detecting urethral, cervical, vaginal and anal infection of these organisms with a single specimen; as organisms in secretions from any of these sites can be present on the vulva and wash into the urine specimen. When infection with *N.gonorrhoeae* is likely, an additional swab from the suspected site/s for culture allows antibiotic sensitivity to be determined, as resistance is an increasing problem in managing this infection.

A vaginal swab sent for wet preparation, microscopy and culture can detect *T.vaginalis* as well as non-sexually transmitted organisms that may cause

[2] The writing group supports the guidelines for specimen collection provided by Doctors for Sexual Abuse Care, DSAC Manual 6th Ed at http://www.dsac.org.nz
Consideration could also be given to young women collecting their own vaginal swabs.

vaginal and vulval symptoms such as Streptococcus, Staphylococcus, E. coli and Candida spp. In some laboratories, NAA is available to detect *T.vaginalis*, from a vaginal swab. Any atypical areas of skin in the anogenital area can be swabbed for herpes simplex virus (HSV) PCR, which has greater sensitivity than HSV culture. Both HSV type 1 and type 2 can be identified by PCR testing.

A. 2.2 Suspected STI following sexual assault

In circumstances of sexual assault, doctors should note the time interval between the initial assault and the examination to determine whether this falls within the window period for detection of sexually transmitted pathogens such as *Chlamydia trachomatis, Neisseria gonorrhoeae* and *Trichomonas vaginalis*. If the initial exposure was within a few hours or days of the examination, testing may need to be deferred or repeated in 1 week. For example, Chlamydia has an incubation period of 7-21 days. If treatment has not intervened, testing should be performed approximately 14 days after the alleged assault.

When girls are examined following recent sexual assault (defined as within the last 72 hours) the use of prophylactic antibiotics (eg. Azithromycin 1 g stat) should be considered depending on the nature of the alleged assault.

The use of post exposure prophylaxis for HIV, while rarely required, should also be considered in accordance with local guidelines[10].

Concerns have been raised about the specificity of testing techniques for Chlamydia and gonorrhoea, other than culture. Culture is 100% specific. NAA has a very low false positive rate. However, NAA is a more sensitive test, therefore NAA has a lower risk of missing the diagnosis of these infections.

For medico-legal purposes, unless treatment has already intervened consideration should be given to confirming, by culture, a positive NAA test result for gonorrhoea.

In medicolegal situations and when legally valid consent from a sexually active young woman is not an issue, Chlamydia infection should also be confirmed by either culture or a second NAA using different methodology which targets a different sequence of the genome to the initial test.

References

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