Case Study

Genital Lichen Sclerosus Mistaken for Child Sexual Abuse and Genital Mutilation

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Abstract

Child sexual abuse is a severe and widespread problem across the globe. The sexual exploitation of children is incomparable whose dynamics are very unusual to that of adult sexual abuse and hence should be handled and investigated differently. Failure to misdiagnose sexual abuse can expose the children to the risk of further abuse and may lead to serious consequences. This case report describes the forensic examination of a 17-year-old girl who primarily presented to the obstetrics and gynecology department with complaints of episodic acute urinary retention and difficulty in passing urine. While evaluating her, the primary physicians observed complete adhesion and fusion of labia majora. This unusual presentation made the examining physicians suspicious of genital mutilation and child sexual abuse. The examination revealed that the labia majora was less appreciable and was fused like parchment-like skin with no visualization of labia minora, clitoris, hymen and vaginal opening. There were no fresh signs of injuries to the anogenital region and no evidence of any surgical procedure done in the recent past suspected to be of genital mutilation. The local examination findings and absence of signs of trauma or surgical scar marks disproved the suspicion of genital mutilation and sexual abuse. The patient's condition was diagnosed with lichen sclerosus et atrophicus, causing genital labial sclerosus. The attending physicians often mistake such conditions as signs of suspected sexual abuse and if not correctly identified, may invite unwarranted child abuse inquiry by law enforcement authorities.

Keywords: Forensic examination, lichen sclerosus, complete labial fusion, child sexual abuse, genital mutilation.

Introduction

Child sexual abuse is a severe and widespread problem across the globe. The exact prevalence of CSA is not known; however, a recent systematic review of 55 studies from twenty-four countries has found that in females and males, it ranged from 8 to 31% and from 3 to 17% respectively[1].In India, CSA is highly prevalent, adversely affecting children's health with

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an estimate that about 10-55% of boys and 4-41% of girls attending schools and colleges have experienced at least one form of CSA[2]. To address this issue, the Government of India passed the much-needed law The Protection of Children from Sexual Offences Act (POCSO), in 2012. This law provides penal provisions for many actions which include sexual assault, exploitation for pornography and aggravated sexual assault involving children less than 18 years of age. The act also mandates the setting of Special Courts to expedite the trials in such offences. The relevant role of medical and health professionals is mentioned in the POCSO Act, of 2012. It ranges from reporting the case to the police, taking history, documenting the injuries, confirming sexual abuse, providing medical care, collecting forensic evidence and testifying in a Court of law[3].

The sexual exploitation of children is incomparable whose dynamics are very unusual to that of adult sexual abuse and hence should be handled and investigated differently. It is said that in children disclosure of sexual abuse does not occur immediately after the incidence rather it occurs during a process rather than a single incidence often initiated after a complaint or a behavioural change [4].Failure to misdiagnose sexual abuse can expose the children to the risk of further abuse. Similarly, serious consequences arise when sexual abuse is misdiagnosed in a child, like removing the child from parental care to foster care, prosecution of an innocent person, unnecessary medical examination, diagnostic evaluation and unpleasant police investigations. Many skin conditions of the genitalia can mimic signs of sexual abuse in children leading to erroneous diagnoses. Streptococcal infection, poor hygiene, vaginitis, and lichen sclerosis can produce redness, fissures, inflammation, vaginal bleeding, and hypopigmentation around the genitalia region are often misdiagnosed as evidence of genital abuse [5].

This case report illustrates a rare case of complete labial fusion in an adolescent unmarried girl primarily referred by obstetric surgeons for forensic opinion with an initial impression of sexual abuse and genital mutilation. The rare presentation of genital labial sclerosis due to Lichen Sclerosus [LS], in this case, posed a confusing problem in its diagnosis and subsequent management. A search of the literature revealed very few cases where LS was mistaken for sexual abuse in children[6-11]. Failure to recognize the underlying disorder may initiate a child abuse inquiry by law enforcement authorities, thereby causing resentment and distress. The present case is probably the first to be reported from India.

Case Report

A 17-year-old unmarried girl presented to the Department of Obstetrics and Gynaecology with complaints of difficulty passing urine (thin stream of urine) with episodic acute retention of urine for the past two years. She had one episode of urine retention previously, which was relieved in a private hospital following catheterization. According to her parents, the child had a history of eruptions and pruritis in labia majora, which were relieved after medication. The patient had her menarche at the age of 12 years and had normal external genitalia since birth.

On examination, adhesion and fusion were present in the whole of labia majora with a single pinpoint opening at the midline for urinary and menstrual blood discharge. Ultrasonography (USG) revealed a trabeculated thick wall urinary bladder suggestive of chronic outlet obstruction. The ovaries and uterus were normal. The examining physicians were baffled by the absence of the typical structures of female genitalia like labia minor, hymen, clitoris, vaginal and urethral opening. Instead, a tiny orifice was seen discharging foul-smelling pus. The unusual presentation made the examining physicians suspicious of genital mutilation type III and sexual abuse, and the case was referred for forensic opinion.

After taking informed written consent, a forensic examination was done where the patient denied any history of sexual intercourse or assault or genital mutilation. There were no injuries on the body of the child. Local genital examination revealed that labia majora was ill-developed and was fused like parchment-like skin. Labia minora and vaginal orifice were not visualized **[Fig. 1].** A single pinpoint opening was present in the midline. A delimited, whitish, and atrophic area of skin near the thighs, the perineum and the perianal region, was appreciable. Furthermore, the anus and perineal region showed no signs of harm. There was no evidence of new or old injuries to the external genitalia. Also, there

was no evidence of any operative procedure done in the recent past. Given the history elicited by the patient and parents and local examination findings, forensic opinion was restricted to diagnosing it as genital malformations ruling out the diagnosis of genital mutilation and abuse. Against the backdrop of all the results, the diagnosis of LS was established and confirmed by the Dermatologist. The patient was operated on for adhesiolysis, labioplasty and clitoroplasty with skin grafting by Plastic surgeons restoring her normal genitalia **[Fig.2].** Later the patient was discharged after successful treatment and attended routine follow-up in the OPD of the hospital.

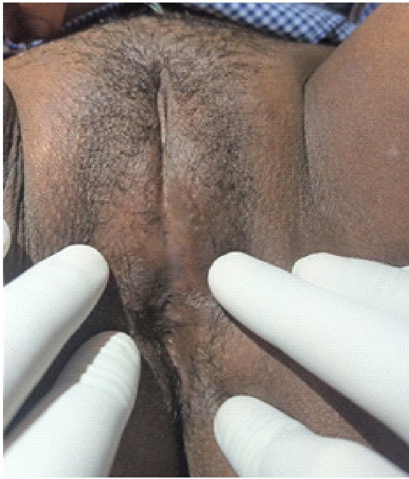

Figure 1: Complete labia majora fusion and a small pinpoint opening in the midline.

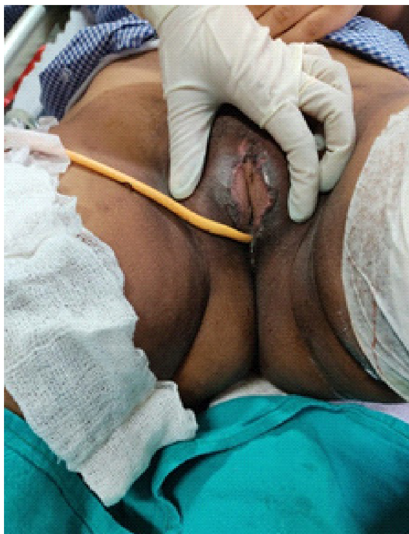

Figure 2: External genitalia showing labia majora with draining catheter in-situ after operation

Discussion

The case presented here demonstrates the atypical presentation of LS in a child affecting the genital region, thereby mistakenly diagnosed as a case of sexual abuse and genital mutilation. It also demonstrates the often widespread uncertainty of attending physicians with the diagnosis of LS. Lichen sclerosus et atrophicus (LSA) or LS is commonly misdiagnosed as a chronic progressive inflammatory disease of the vulvovaginal area with unclear aetiology. However, some newer evidence suggests a possible auto-immunogenicity process or genetic predisposition in its aetiology mainly affecting dermal and epidermal tissues of the anogenital region[12-16]. It predominantly affects postmenopausal women with children accounting for just 10-15% of all instances[17]. It is characterized by whitish, hypopigmented areas of skin in the anogenital region[6].

Itching is the most common symptom of LS. Still, vulvar pain, dysuria, persistent constipation, recurring ecchymoses, and bloodstaining of the underpants are all possible signs, but the vagina and hymen are unaffected[7-9,18-19]. Due to the chronic course, patients can develop sclerotic plaques, labial fusion, ecchymoses, genital atrophy, contraction and stenosis of the urinary tract and the vaginal orifice[6, 20-21]. When LS affects a girl's vulva, the skin becomes thin, fissured, and easily damaged by little pressure or friction, leading to haemorrhages and contusions. This finding may be misinterpreted as injury, particularly sexual assault, and may lead to false allegations and hostile investigations[17]. Contrasting to sexual assault trauma, the hymen is intact and not involved in LS[17-18]. Though it's dangerous to diagnose LS avoiding misinterpretation of sexual assault in children, it is vital to understand that the two diagnoses are not mutually exclusive[10,20,22]. When needed, a comprehensive laboratory and multidisciplinary evaluation to rule out sexual abuse are required. Hymenal trauma is a crucial indicator of sexual abuse, independent of the kind of abuse[11].

The second diagnosis suspected by the primary physicians, in this case, was that of female genital mutilation. Female circumcision (FC) or female genital mutilation (FGM) describes practices that manipulate, alter, or remove the external genital organs in young girls and women for non-medical

reasons[23-24]. There are four different types of FGM as per the WHO classification, and the current estimates indicate that around 90% of cases include Type I, II and IV, and about 10% are Type III[25]. Usually, women carry out these procedures with no medical training using tools such as scissors, knives, scalpels, pieces of glass and razor blades without using anaesthesia or antiseptic treatment. However, these procedures in recent years have been carried out in healthcare settings by trained healthcare personnel[26]. A visual reference tool is provided for healthcare workers to diagnose the types and subtypes of FGM. [27] In India, the custom of FGM and FC is commonly practised in the Bohra community, and is referred to as "Khatna" or "Khafz/Khafd". The process involves cutting the tip of a girl's clitoris usually at the age of 6-7 years, generally done by a traditional cutter or "semi-religious mullanis" or any experienced woman[28,29].

In the present case, the aid of a forensic physician was rightfully requested since the primary care physicians could not explain the findings and misdiagnosed the genital labial sclerosus as child sexual abuse and genital mutilation. However, subsequent forensic examination disproved this diagnosis owing to the lack of signs of fresh or old anogenital injuries and the absence of surgical scar marks over the external genitalia. The history elicited by the patient and her parents also helped in excluding the diagnosis of sexual abuse and genital maiming. The patient was not reported to the legal authorities because the work-up revealed no evidence of sexual abuse, and the diagnosis was confirmed as Lichen Sclerosus subsequently by the hospital dermatologists.

In lichen sclerosus et atrophicus, the skin becomes thin and easily damaged, increasing the susceptibility to trauma. Minor injuries and bruises may be magnified and can raise suspicion of possible childhood sexual abuse[11]. Trauma to the hymen is an essential marker in identifying if sexual abuse has occurred or not, regardless of the presence of lichen sclerosus[8]. The lack of awareness in diagnosing this condition in children often leads to confusion and notifying it as CSA by the healthcare providers, frequently leading to sexual abuse investigations, which are highly traumatic for the child and everyone involved[6,9,30].These suspicious lesions warrant appropriate investigation, which can be distressing for all concerned involved in paediatric care. Failure to identify these lesions of lichen sclerosus et atrophicus can lead to unsuitable forensic investigations.

Conclusion

The present case demonstrates many skin conditions of the genitalia can mimic signs of sexual abuse in children leading to erroneous diagnosis, in this case, LS. The implications of identifying child abuse are reasonably well understood from a forensic standpoint however misdiagnosing them will cause unnecessary child sexual victimization. In the worst-case scenarios, criminal prosecution might result in the unjustified imprisonment of suspects. The present case report substantiates that a multidisciplinary approach in the examination is needed to confirm the accurate diagnosis in such a confusing presentation of illnesses to avoid painful legal investigations. Since physical force is seldom inflicted, the conclusive signs of genital trauma are rarely seen in child abuse cases and accurate interpretation of genital findings requires specialist training, and wherever possible, experts in this field should be consulted.

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Declarations

Ethics Approval - Not required

Consent for publication – Informed consent was taken from the patient for publication of information

Consent for photograph – Informed consent was taken from the patient for publication of photographs

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Authors Contribution:

1. Dr Amit Patil - supervised forensic examination, draft manuscript writing, literature review, editing, finalization of the manuscript.
2. Dr Mukta Agarwal – primary care physician, examined and operated on the patient.

3. Dr Prabhat Kumar – performed the forensic examination.
4. Dr Himanshi Narang – assisted in the forensic examination, manuscript writing, and literature search.
5. Dr Shashank Ranjan – assisted in the manuscript writing and literature search.

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