International Journal of Scientific Reports
Oriji PC et al. Int J Sci Rep. 2021 Apr;7(4):247-250
http://www.sci-rep.com
pISSN 2454-2156 | eISSN 2454-2164

DOI: https://dx.doi.org/10.18203/issn.2454-2156.IntJSciRep20211041

Case Report

Isolated upper vaginal wall laceration in an underage: a need to re-examine child sexual abuse in South-South Nigeria

Peter Chibuzor Oriji*, Ebiye S. Tekenah, Olakunle I. Makinde, Tonebimonyo J. Wagio, Nnamdi C. Nwanze, Barbara Eneni

Department of Obstetrics and Gynaecology, Federal Medical Centre, Yenagoa, Bayelsa State, Nigeria

Received: 08 February 2021
Accepted: 12 March 2021

***Correspondence:**
Dr. Peter Chibuzor Oriji,
E-mail: chibuzor54@gmail.com

ABSTRACT

Child sexual abuse includes any sexual act between a minor and an adult, or between two minors, when one exerts power over the other. It involves forcing, coercing or persuading a child to engage in any type of sexual act. It also involves non-contact acts such as exhibitionism, exposure to pornography, voyeurism, and communicating in a sexual manner by phone or internet. An eight-year-old girl was rushed to the gynaecological emergency unit of the Federal medical centre, Yenagoa with complaints of a three-hour history of sudden onset vaginal bleeding following a fall astride in their house. There was no injury to the vulva and the child and her relatives denied any form of sexual abuse by anyone within or outside their home. She had examination under anaesthesia in theatre and a 3 cm laceration was identified at the proximal one-third of the left lateral wall of the vagina, covered with a blood clot; not bleeding actively. Repair was done and she was subsequently discharged home on the fourth post-operative day after counselling of mother and child. Child sexual abuse is common in our environment. Education and bonding with children, education of the public via outreaches, social media campaigns and other means possible, and improvement in the socio-economic situation of people will help reduce the incidence of child sexual abuse and encourage reporting and early disclosure where they occur.

Keywords: Child sexual abuse, Vaginal laceration, Vaginal bleeding

INTRODUCTION

Vaginal lacerations following coitus are under-reported in our environment especially when it occurs in an underage girl. These lacerations vary from minor self-limiting vaginal injury with minimal bleeding, which do not require medical attention to life threatening laceration with severe bleeding which has the capacity to progress to haemorrhagic shock and death if not promptly and adequately managed.[1-3] The concern of a gynaecologist when vaginal examination of an underage girl is necessary, is the presence of the hymen which will hinder such examination. The gynaecologist becomes more concerned when the hymen is not intact in an underage girl. This is not uncommon in children being sexually abused, and many times evidence of recent trauma is not present.

This case report highlights a clinical suspicion of child sexual abuse that was complicated by genital laceration.

CASE REPORT

An eight-year-old girl was rushed to the gynecological emergency unit of the Federal medical center, Yenagoa with a three-hour history of sudden onset of vaginal bleeding following a fall astride in their house. Her mother was said not to be in the house, but was called back home when the incident happened. They could not quantify the bleeding, but it was said to be significant,

markedly staining the floors of their living room and passage. There was no vulva injury, fracture of any bone following the fall or the presence of any sharp object on the floor before the fall astride. The child and her relatives denied any form of sexual abuse by anyone within or outside their home. The child's mother is unmarried, and lives in a family house of three-bedroom flat, where there are other children and adults of both sexes. When bleeding continued with associated dizziness and progressive weakness, she was rushed to the gynecological emergency of the Federal medical center, Yenagoa, Bayelsa state, Nigeria for management.

Examination revealed a lethargic girl. She was markedly pale, anicteric, afebrile with an axillary temperature of 36.9℃. Her pulse rate was 106 beats/minute and her respiratory rate was 40 cycles/minute. Her blood pressure was 70/40 mmHg. Her abdomen was full and moved with respiration; with no areas of tenderness. There was no injury in any form to the external genitalia. Further examination was hindered by patient's anxiety despite the presence of her mother and calming reassurances from the mother and doctor. A diagnosis of vaginal bleeding in shock was made. Help was called for. Her hemoglobin concentration was 12 g/dl (a suggestion of acute blood loss). As she was being resuscitated with 1 liter of intravenous fluid normal saline, two units of blood were immediately grouped and cross-matched for her, and commenced. The findings and diagnosis were explained to the mother. She was counselled for immediate examination under anesthesia in theatre. The procedure was explained to the mother and an informed consent obtained. Theatre was booked for the procedure and she was quickly wheeled to the theatre.

On examination under anesthesia, the hymen was reduced to only remnants with no evidence of recent injury, the vaginal introitus was gaping and the vaginal rugae was readily visible (Figure 1). A gentle sterile speculum examination revealed a 3 cm laceration at the upper one-third of the left lateral wall of the vagina, covered with a blood clot; not bleeding actively but bled on contact (Figures 2 and 3). There was grossly normal cervix. The laceration was repaired in continuous non-locking pattern with vicryl 3/0 sutures. The blood loss at surgery was about 120 ml. Her immediate postoperative condition was satisfactory. Post-operative impression was a highly probable post-coital vaginal laceration.

The intraoperative findings were explained to the mother who denied any prior knowledge of sexual abuse of the patient. She was counselled to be more vigilant and observant of happenings and people around the child. The patient received one more unit of blood post-operation, antibiotics and analgesics. Her post-transfusion hemoglobin concentration done on the second post-operative day was 11 g/dl. The results of other investigations including HIV and STI screening were negative. She was discharged home on the fourth post-operative day with two weeks appointment to the gynecological clinic after counselling of both mother and child on need for disclosure of any knowledge of ongoing sexual abuse.

At the follow-up visit, she had no complaints and her general condition was satisfactory. The vaginal wound had healed satisfactorily. Her mother was counselled on proper child care.

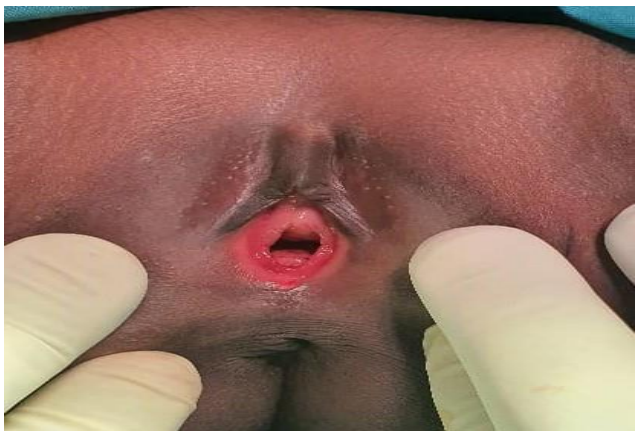

Figure 1: The hymen reduced to only remnants with no evidence of recent injury, the vaginal introitus was gaping and the vaginal rugae was readily visible.

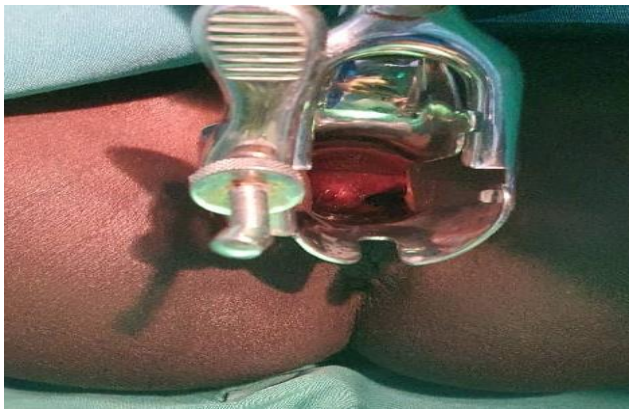

Figure 2: Laceration at the upper one-third of the left lateral wall of the vagina, covered with a blood clot; not bleeding actively.

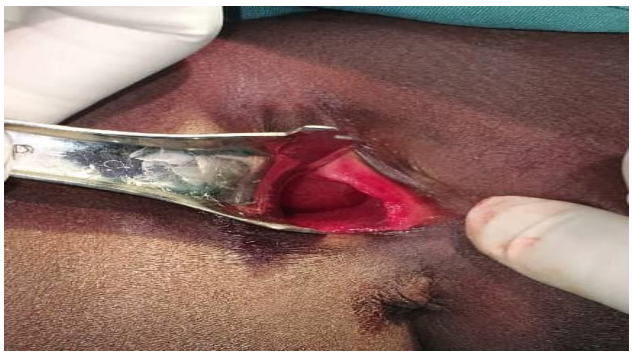

Figure 3: 3 cm laceration at the upper one-third of the left lateral wall of the vagina.

DISCUSSION

Child sexual abuse includes any sexual act between a minor and an adult, or between two minors, when one exerts power over the other. It involves persuading, forcing or coercing a child to engage in any form of sexual activity. It also involves non-contact acts such as voyeurism, exposure to pornography, communicating in a sexual manner through the internet or phone and exhibitionism.[4]

Child sexual abuse is more common than we think it is. It may be the most common health problem that children pass through.[5] One out of 10 children will be sexually abused before the age of 18 years, and one out of seven girls and one out of 25 boys will be sexually abused before they become 18-year-old.[1] It is only about 38% of child abuse victims that disclose the fact that they have been sexually abused,[6,7] some never disclose.[8,9] The victims are often threatened not to tell anyone about what had happened to them. Child abusers can be family members, neighbors and friends, and are found in families, Churches, Mosques, schools and other places where children gather. Children can also abuse other children. About 90% of children who have been sexually abused know their abusers.[10,11] Only 10% of sexually abused children are abused by a stranger.[10] Approximately 30% of children who are sexually abused are abused by family members.[10,11] The younger the child, the more likely it is that the abuse was perpetrated by a family member.

To prevent social stigma and protect the abuser, parents often do not disclose child abuse. This is a very possible situation in the case presented. Not reporting child sexual abuse is dangerous as it may be an indirect signal for the perpetrators to continue abusing the children. Government, child right advocates and practitioners need to educate parents on this danger. Prosecution and punishment for offenders of sexual abuse has the potential to deter other would-be offenders.[12] While barriers to disclosure by victims of child sexual abuse continue to outweigh facilitators, Nigeria still lacks an organised system for reporting clinical suspicion of child sexual abuse.[13]

Risk factors for perpetration of abuse include: family risk factors (history of abuse on the abuser, poor family background, poor family bonding and poor upbringing); externalising behaviours (aggression/violence, anger/hostility, substance abuse, non-violent criminality, paranoia/mistrust); internalising behaviours (history of mental illness, anxiety and low self-esteem); social deficits (low social skills, loneliness, difficulties with intimate relationships); sexual problems (deviant sexual interest), and cognitions/attitudes tolerant of adult child sex and minimising the perpetrator's culpability.[14]

Coital laceration is one of the complications that could arise from child sexual abuse. Others include injuries to the body, pregnancy, urinary tract infection, HIV infection and other sexually transmitted infections, depression, post-traumatic stress disorder, long-term emotional and psychological damage, constant fear, poor academic performance, low self-esteem, and death. A patient with coital laceration may present in shock if she does not present to the hospital early, just as was seen in the case presented, and further complications may ensue if presentation or management is delayed further including death.[15] Coital lacerations are commoner at the posterior fornix of the vagina.[1-3,15] In the case presented, the laceration was at the upper third of the left lateral wall of the vagina. Other complications of coital laceration include haemorrhage, injury to abdomino-pelvic organs, peritonitis, sepsis, vaginal stenosis, recto-vaginal fistula, vesico-vaginal fistula and death.

Recommendation of preventive strategies for child sexual abuse will include the following: to bond and communicate regularly with children; to teach children about relationships and how to maintain their boundaries, especially when they are touched; children should be taught that being touched or any form of sexual abuse is not a safe secret to keep' children should be taught about healthy sexual development. children should be helped to identify adults they can confide in; the use of internet and television programmes that children watch should be monitored by their parents and guardians; any child that exhibits any inappropriate sexual behavior should be seen by a professional for adequate counselling; child sexual abuse prevention programmes should be regularly organized in schools, churches, mosques and other places of worship, and our communities; regular campaigns against child sexual abuse should be carried out; any case of child sexual abuse should be reported to the authorities, irrespective of who is involved.

CONCLUSION

Child sexual abuse is common in our environment and underreported. Education and bonding with children, education of the public via social media campaigns, outreaches and other means possible, and improvement in the socio-economic situation of people will help reduce the incidence of child sexual abuse, and encourage reporting and early disclosure where they occur.

ACKNOWLEDGEMENTS

The authors would like to thank the mother of this patient, and all members of the managing team for the roles they played in the management of this patient.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

REFERENCES

1. Fletcher H, Bambury I, Williams M. Post-coital posterior fornix perforation with peritonitis and hemoperitoneum. Int J Surg Case Rep.

2013;4(2):153-5.
2. Jeng CJ, Wang LR. Vaginal laceration and haemorrhagic shock during consensual sexual intercourse. J Sex Marital Ther. 2007;33(3):249-53.
3. Sloin MM, Karimian M, Ilbeigi P. Nonobstetric lacerations of the vagina. J Am Osteopath Assoc. 2006;106(5):271-3.
4. Townsend C. Rheingold AA. Estimating a child sexual abuse prevalence rate for practitioners: a review of child sexual abuse prevalence studies, 2013. Available from: https://www.d2l.org/wp-content/uploads/2017/02/PREVALENCE-RATE-WHITE-PAPER-D2L.pdf. Accessed February 7, 2021.
5. Townsend C. Prevalence and consequences of child sexual abuse compared with other childhood experiences, 2013. Available from: https://www.d2l.org/wp-content/uploads/2016/10/MOST-SIGNIFICANT-SEVERE-LONGTERM-PAPER-D2L.pdf. Accessed February 7, 2021.
6. London K. Bruck M, Ceci S, Shuman D. Disclosure of child sexual abuse: What does the research tell us about the ways that children tell? Psychol Public Policy Law. 2003;11(1):194-226.
7. Ullman SE. Relationship to perpetrator, disclosure, social reactions, and PTSD symptoms in child sexual abuse survivors. J Child Sexual Abuse. 2007;16(1):19-36.
8. Broman-Fulks JJ, Ruggiero KJ, Hanson RF, Smith DW, Resnick HS, Kilpatrick DG et al. Sexual assault disclosure in relation to adolescent mental health: Results from the National Survey of Adolescents. J Clin Child Adoles Psychol. 2007;36:260-6.
9. Smith DW, Letourneau EJ, Saunders BE, Kilpatrick DG, Resnick HS, Best CL. Delay in disclosure of childhood rape: Results from a national survey. Child Abuse Neglect. 2000;24:273-87.
10. Finkelhor D, Ormrod R. Characteristics of crimes against juveniles. Washington DC, USA: US Government Printing Office, 2012.
11. Whealin J. Child Sexual Abuse. Post-Traumatic Stress Disorder, 2007. Available from: https://www.ptsd.va.gov/professional/treat/type/sexual_abuse_child.asp. Accessed February 7, 2021.
12. David N, Ezechi O, Wapmuk A, Gbajabiamila T, Ohihoin A, Herbertson E et al. Child sexual abuse and disclosure in South Western Nigeria: a community-based study. Afr Health Sci. 2018;18(2):199-208.
13. Alaggia R, Collin-Vézina D, Lateef R. Facilitators and Barriers to Child Sexual Abuse (CSA) Disclosures: A Research Update (2000-2016). Trauma Violence Abuse. 2019;20(2):260-83.
14. Whitaker DJ, Le B, Hanson K, Baker CK, McMahon PM, Ryan G et al. Risk factors for the perpetration of child sexual abuse: Meta-analysis. Child Abuse Neglect. 2008;32:529-48.
15. Oriji PC, Omietimi JE, Allagoa D, Sominyai IRC, Adeniran A, Ikiba P et al. Coital laceration in shock: a case report. Yen Med J. 2019;1(1):49-51.

Cite this article as: Oriji PC, Tekenah ES, Makinde OI, Wagio TJ, Nwanze NC, Eneni B. Isolated upper vaginal wall laceration in an underage: a need to re-examine child sexual abuse in South-South Nigeria. Int J Sci Rep 2021;7(4):247-50.