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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

The medical examination of sexually abused children

SIR,—In her timely paper on the need for sexual assault centres in the UK (9 March, p 771) Dr May Duddle briefly mentions that "the needs of child victims of sexual assault are more easily met." We wholeheartedly support her approach in distinguishing between the needs of sexually abused children and rape victims. We also support Dr Raine Roberts's plea for special facilities for investigation and examination in cases of sexual assault (23 March, p 935).

At present, however, there exists considerable lack of clarity about what constitutes an appropriate medical examination of these children, many of whom are prepubertal (and an increasing number of whom are boys). Specifically, there are questions about where and when they should be examined, by whom, and what should be included in the examination.

In drawing up local guidelines, we have reached the following conclusions, which we would like to share with your readers. Firstly, the examination should be carried out in a hospital room, preferably part of the paediatric outpatient or casualty department. It should not take place in a police station, since this is extremely likely to compound the guilt which many sexually abused children already experience.

Secondly, the child should first be interviewed by a specially trained social worker, psychiatrist, psychologist, or paediatrician, together with a plainclothed police person and in the presence of a trusted adult, to gain an account of the child's experiences. The interview should take place in a room near the medical examination room. The child's account will inform the kind of examination likely to be necessary, as well as excluding the need for some procedures. The interview provides a natural context for the examination, as a result of which the child may be reassured that she has not been physically damaged. (In at least 50% of sexually abused children there is no physical evidence of the abuse at the time of examination.) This sequence would have to be reversed in cases where the child has very recently been abused and is in need of urgent medical attention.

Thirdly, the designation of the examining doctor is less relevant than her training and skill. The doctor should: (*a*) be willing and available to give evidence in court; (*b*) be accustomed to talking to and examining children of even a very young age; (*c*) be familiar with what constitutes the normal anatomy of genitalia of young children, particularly the size of vaginal opening and anal tone; (*d*) be familiar with the circumstances which merit the collection of forensic specimen; (*e*) be trained in the collection of forensic and microbiological specimens when appropriate. In practice, often all that is required is a glance to exclude bruising and redness and establish that the child's hymen is still intact and vaginal opening small.

It is, however, our experience that there are very few doctors who are currently able to fulfil all these criteria, and we would advocate that local training programmes should be established now. Whether or not it reveals evidence of sexual abuse the physical examination is the starting point for necessary therapeutic work with these children and their families.

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AIDS: the African connection?

SIR,—Dr Peter Jones expressed the view that "if plasma from endemic areas is still being used plans for screening are clearly inappropriate" (23 March, p 932). Under the Medicines Act information about sources of plasma is provided by the licensing authority in confidence by the companies concerned. I can, however, assure Dr Jones and others concerned with this issue that on the basis of that information we are satisfied that none of the plasma covered by current UK licences comes from areas where AIDS is known to be endemic.

Efforts are being made to make Britain self sufficient in blood products. A substantial investment has been made to redevelop the Blood Product Laboratory at Elstree and this should open early in 1986. It will, of course, process plasma obtained exclusively from the volunteer donors of the National Blood Transfusion Service. Tests to screen blood donations for HTLV-III antibody are being developed both in Britain and abroad. The Minister for Health announced on 20 February that we are coordinating the evaluation work needed to ensure that a properly validated test can be introduced into the National Blood Transfusion Service as soon as possible.

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