

Case study

A case of an acquired rectovaginal fistula and faecal incontinence in a 4-year old girl from sexual assault

Abstract

Background

Child Sexual Abuse (CSA) is a crime against children. It is largely underreported and commonly goes unpunished in our society.

Case report

The patient is a 4-year old girl who presented with few hours fecal incontinence. She suddenly developed fecal incontinence and was walking with difficulty with complaints of pain. The child told the mother that the landlord son forced his penile gland into her anus and inserted his fingers through her vagina. On examination of her anal region, there was anal sphincter tear at 6 O clock, extending exteriorly to the right measuring 1 cm long and 0.5cm deep with a rectovaginal fistula. Vaginal examination revealed minor laceration and excoriation on the right lateral wall and floor of the vagina, with mild bleeding. She had a left hymenal tear at the lower aspect and a vagina floor tear. Results of urine MCS revealed wbc 2+, leucocytes 2+, epithelial cells+, staphylococcus aureus was isolated.

The child was resuscitated and given antibiotics and analgesics and prophylactic antiretroviral drugs. She had a perineal tear repair by the paediatric surgeon. She was placed on sitz bath and she responded well with good healing and recovery. She was discharged after 2 weeks and came back for follow-up.

This report highlights the management of a case of rectovaginal fistula in a child as a result of sexual assault.

Key words: sexual assault, recto-vaginal fistula, child sexual abuse

Introduction

Child Sexual Abuse (CSA) is a crime against children. CSA can be defined as the

Involvement of a child in sexual activity that he/she does not understand, is not developmentally prepared for and is unable to give informed consent. CSA can be in the form on contact or non-contact form. The contact form involves physical contact between the perpetrator and the victim. This contact could be in the form of playing with the child's genitals, oral-genital contact, digital penetration and vaginal and anal penetration. The non contact form includes: Pornography, voyeurism and exhibitionism [1]. The perpetrator usually trick or deceive the children with gifts and sweet words , however, some force the children to have sexual intercourse with them (rape). This is the worst form of CSA [2].

The prevalence of child sexual abuse differs world wide. In an epidemiological overview on the prevalence of CSA worldwide, the study was carried out in 22 countries with over 65 studies. The prevalence rate of 23%, 10%, and 9.2% was gotten for Asia, America and Europe respectively [3]. The highest prevalence rate was said to be in Africa with 34%. However, the highest prevalence rates are reported among the female gender in about seven countries in the world; 24% in Switzerland, 25% in USA, 28% in Sweden, 30% in Israel, 31% in Tanzania, 32% in Costa Rica, 32% in Australia. A systemic review done for all Asian studies on child abuse showed that prevalence of CSA ranged from 2.2% - 94% for girls and 1.7% - 49.5% for boys [4].

In Nigeria, the prevalence also varies from different zones, setting and from people of different socio-demographic background. A review of 20 studies showed a prevalence rate of as low as 0.6% to as high as 95%. The reason for this diversity could be because of the studies were conducted from the 6 different geo-political zones in the country, the settings were also different, because those conducted in the hospital had the lowest prevalence and this could be explained by the fact that people do come to the hospital unless there is an injury that will require medical intervention. Other reasons include the fact that they were mostly retrospective studies, they all used different definition [5-8]. However, the true prevalence of CSA in Nigeria is unknown. The reasons are: the culture of silence, taboo, shame, guilt, stigma and ineffectual persecution of offenders [9].

Studies have shown that CSA is more common in females than males, occurs in familiar settings, offenders are known to the children [5-8]. The perpetrators are usually known to the victims, they could be Fathers, brothers, uncles, Nephews, Cousins, family friends or neighbours. The risk factors associated with CSA include poverty, ignorance, poor education, and unstable home environments [5-8].

CSA is largely under reported and commonly goes unpunished in our society.

Aim: To highlight the occurrence of rectovaginal fistula and faecal incontinence in a child from sexual assault.

Case Report.

The patient is a 4 year old girl who presented with 14 hours history fecal incontinence and leakage of faeces from the vagina. She was said to be apparently well until 14hrs prior to presentation, when she suddenly developed fecal incontinence, walking with difficulty, perineal pain associated with rectal bleeding.

There was no preceding history of fall, when questioned by the mother, the child said that their landlord's son called her his apartment and forced his penis into her anus and inserted his fingers through her vagina. This is the first time he is doing that. The child is yet to start school.

She is the only child of her parents, they live in a compound with the landlord and his 19 year old son who is a school dropout. The mother is a house wife while the father is a trader.

Vaginal examination revealed hymenal avulsion with redundant hymen on the left, minor laceration and excoriation on the right lateral wall and floor of the vagina, with mild bleeding.

Perianal examination reveal perianal fecal soilage, patulous anal, torn anal sphincter and tear at 6 '0 clock, extending exteriorly to the right measuring 1 cm long and 1.5cm deep with a rectovaginal fistula.

Diagnosis: Genital injuries with third degree perineal lesion from sexual assault.

Results of urine MCS revealed wbc 2+, leucocytes 2+, epithelial cells+, staphylococcus aureus was isolated.

RVS- Negative

FBC-WBC-8,300, PCV-33%, platelets-265, Neutrophil-57%, Lymphocytes-34%,

Monocytes -07%, Eosinophils-02%

U/E-BUN-4.7mmol/L ↔ ., Cr- 12-μmol/L. Na- 135mmol/L ↔ , K+-4.0mmol/L ↔ ,

Cl-111mmol/L ↔ .

Treatment: The child was given antibiotics, analgesics and sitz bath. She had a repair of genital injuries (Vaginoplasty, Sphincteroplasty and repair of perianal tear). She responded well with good wound healing and was discharged after 20 days with follow-up at the Paediatric out-patient unit.

Discussion

Sexual assaults is a barbaric crime that leaves the victim with both physical, emotional and psychological trauma, that may affects the victim through out their life time[10].

Girls are usually more affected than boys, like our index case[5]. CSA occurs more in adolescents than under- fives, however, our victim is a 4year old girl [5,11].

Our index patient was sexually assaulted by her 19year old landlord son who lives in the same compound. The perpetrators are usually known faces, they are either family members, friends and neighbours rather than strangers [2-3,5].

The crime took place in the landlords house, who lives together in the same compound as the child. The venue of the crime is said to occur more at a home or neighbours house rather than outside, which was the case with our victim.

The patient had both fingering and penile penetration into her vagina and anus.

However, the common practice reported are fingering, fondling and kissing, few are said to penetrate the vagina or the anal region [2,5].

The commonest mode of presentation is usually pain in the vaginal or anal region, our patient presented with both pain in the vaginal and anal region with faecal incontinence [2-3,5].

The complication that can arise from CSA can be psychological, physical, health, behavioral and interpersonal. Psychological (trauma, low self-esteem, depression, suicidal, guilt, self-blame and mental health disorder), physical (Vaginal and anal tear, bruises, recto-vaginal fistula), health issues (STI, HIV/AIDS, unwanted pregnancy) Behavioral and social (truancy, juvenile delinquency, sexual risk behaviors, secrecy, lack of trust) [3].

The victim had some of the physical and psychological complications at presentation. The behavioral and social complications may present later in life.

Conclusion: CSA leaves a permanent damage in the mind and body of the victim

Therefore, strict measures must be put in place for the prevention and control of this hideous public health problem.

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