Case study

Acquired rectovaginal fistula and faecal incontinence following sexual assault in a 4-year-old girl.

Abstract

Background

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

Case report

The patient is a 4-year-old girl who presented to our emergency paediatric unit with 14 hours duration of faecal incontinence following sexual assault by her landlord's son. She also complains of pelvic pain and difficulty in walking. The landlords's son forced his penis into her anus and inserted his fingers through her vagina.

On examination of her anal region, there was anal sphincter tear at six 0' clock, extending exteriorly to the right measuring 1 cm long and 0.5 cm 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 microscopy culture and sensitivity (MCS) revealed white blood counts (WBC) 2+, leucocytes 2+, epithelial cells+, *Staphylococcus aureus* was isolated which was sensityive to amoxiciilin.

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 on admission 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.

Keywords: 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 or some force the children to have sexual intercourse with them. 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, which 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%. 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 in 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 not present 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 neigbours. 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 to our emergency paediatric unit with 14 hours' duration of faecal incontinence following sexual assault by her landlord's son. She also complains of pelvic pain and difficulty in walking. The landlord's son forced his penis into her anus and inserted his fingers through her vagina.

There was no preceding history of fall, she said the landlord's son called her into 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. she 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 1.5 cm deep with a rectovaginal fistula.

A diagnosis of genital injuries with third degree perineal lesion from sexual assault was made.

Results of urine of urine microscopy culture and sensitivity (MCS) revealed white blood counts (WBC) 2+, leucocytes 2+, epithelial cells+, *Staphylococcus aureus* was isolated sensitive to amoxicillin..

Retrovital screening test was negative.

Full blood count- white blood count-8,300, PCV-33%, platelets-265, Neutrophil-57%, Lymphoctes-34%, Monocytes -07%, Eosinophils-02%

Urea/Electrolyte-Blood/urea/nitrogen-4.7mmol/L↔ ., Creatinine- 12-µmol/L. Sodium- 135mmol/L↔ , Potassium-4.0mmol/L ↔ , Chloride-111mmol/L↔ .

Treatment: She received antibiotics, analgesics and sitz bath. Intraoperative findings revealed a patulous anal, lax anal sphincter which was torn at 6 '0 clock position with a 1 cm length and 1.5cm deep, also had a rectovaginal fistula. She had a repair of genital injuries (Vaginoplasty, Sphicteroplasty and repair of perianal tear). Vaginoplasty to repair the vagina by suturing the mucosa with vicyrl 5/0, She also had a hymenoplasty to address the hymenal tear. She had a povidone socked guaze placed in the repaired vagina and the anus which was removed after 72hrs. She responded well with good wound healing with good cosmetic results, the reinforced hymenal tissue was intact so also the vagina. The tone of the anal sphincter checked at post-operative day 10 was good and was discharged after 20 days for follow-up at the Paediatric out-patient unit.The patient does interact well with her parents and friends, she is passing stool normally, no more incontinent of stool. She will be followed up to access the functionality of the vagina, adequacy of depth and watch out for any reoccurrence of fistula.

Discussion

Sexual assaults is a babaric crime that leaves the victim with both physical, emotional and psychological trauma, that may affect 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 patient is a 4year old girl [5,11].

Our index patient was sexually assaulted by her 19-year-old landlord son who lives in the same compound. The perpetrators are usually known faces, they are either family members, friends and neigbours 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 neigbours 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 (Sexually transmitted disease, HIV/AIDS,unwanted pregnancy)

Behavioral and social (truancy, juvenile delinquency, sexual risk behaviors, secrecy, lack of trust) [3].

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

Conclusion: The occurrence of acquired recto-vagina fistula following sexual assaults can be devastating. 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.

References

1. Child sexual abuse. American Psychological Association2014. Available from: www.apa.org/pi/.../child-sexual-abuse.(Accessed 2nd January 2022)
2. David N, Ezechi O, Wapmuk A, Gbajabiamila T, Ohihoin A, Herbertson E, Odeyemi K. Child sexual abuse and disclosure in South Western Nigeria: a community based study. Afri Health Sci. 2018;18:199-208
3. Singh MM, Parsekar SS, Nair SN. An epidemiological overview of child sexual abuse. J Family Med Pri Care 2014;3:430–435.
4. Barth J, Bermetz L, Herin E, Trelle S, Tonia T. The current prevalence of child sexual abuse worldwide: a systematic review and meta-analysis. International Journal of Public Health. 2015;58:469-83.
5. Olusola O, Abiodun G, Nwabueze A, Okojide A. Review of Child and Adolescent Sexual Abuse in Nigeria: Implications for 21st Century Counsellors. Covenant Interl J Psychol;5:10-14
6. Ibekwe JM, Ibekwe RC, Obi MU, Mouneke VU, Obu DC, Eke BC. Prevalence and pattern of sexual abuse among children attending Ebonyi State University Teaching Hospital, Abakiliki, Ebonyi State. N J Paediatr 2013;40:2-6
7. Adogu P, Adinma E, Onyiaorah V, Ubajaka C. Perception, Prevalence and Predictors of Rape among female students in a tertiary institution in South-East Nigeria. Inter J Clin Med 2014;5:819-82
8. Adeosun, I. Adolescents Disclosure of Sexual Violence victimization in Nigeria: prevalence, Barriers and Mental Health implication. Int Neuro Psy Die J 2015;4: 153-160.
9. UNICEF.Fact Sheet: Child sexual Abuse. www.unicef.org/lac/break_the_Silence_Initiative- Fact_sheet(1).pdf [accessed 24/10/2021]
10. Fergusson DM, McLeod GF, Horwood LJ. Childhood sexual abuse and adult developmental outcomes: findings from a 30-year longitudinal study in New Zealand. Child Abuse Negl 2013;37:664-74.
11.Odu B, Falana BA, Olotu OA. Prevalence of violent sexual assault on South West Nigeria girls. Europ Sci J 2014;10:471-481