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Anal lesions and suspected sexual abuse in a 17-year-old girl

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A 17-year-old school girl presented to the emergency room accompanied by her mother. Over the previous 2 weeks she had experienced anal paraesthesia and most recently suffered strong anal pain which made sitting almost impossible. She had no history of perianal pain, nor any abdominal pain. Stool frequency and consistency had been normal. She had neither lost weight nor experienced fever.

The clinical examination showed a teenage girl in good health. Inspection of the perineum showed beside skin tags several deep anal fissures. The perianal soft tissues including the anal fold pattern were normal. An increased sphincter tonus together with severe pain made the digital rectal examination impossible. Rectoscopy under general anaesthesia showed three long (>4 cm) anal fissures together with multiple mucosal lesions (figure).

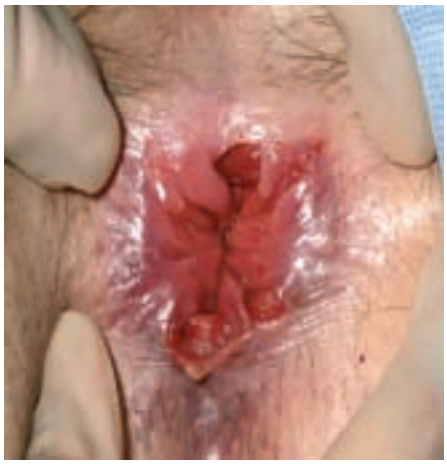

Figure 1
Perianal examination with fissures.

Since there was no indication in the history of inflammatory bowel disease or any disorder with perinal involvement, anal trauma was suspected. A meeting with the girl's parents and a paediatrician from the child protection service did not provide clear evidence of sexual abuse. However, for the first time in her life the patient and her younger sister had been alone at home with their father for 2 weeks while their mother was on vacation. Thus further legal proceedings were debated. We performed a colonoscopy a few days later which showed severe isolated ulcerative ileitis terminalis. Histology confirmed the suspicion of active Crohn's disease. The patient recovered within 8 weeks and remained in remission at 1-year follow-up following initial treatment with metronidazole per os and immunosuppressive therapy with azathioprine.

Anal mucosa lesions and ulcerations without other abdominal symptoms can be caused not only by sexual abuse, infectious diseases or Lichen sclerosus et atrophicans, but also by Crohn's disease. Anal findings in Crohn's disease may be present in up to one third of patients [1]. Isolated perianal Crohn's disease occurs in approximately 10 percent [2]. Perianal involvement comprises a heterogeneous and complex group of lesions consisting of skin tags, fissures, fistulas and abscesses. These findings are often mistaken for sexually transmitted diseases or sexual abuse. Perianal involvement can even precede any clinical symptomatic primary manifestation of intestinal disease [3], as was the case in our patient.

Conversely, the majority (>84%) of sexually assaulted children and teenagers exhibit no physical signs of abuse [4]. Most commonly detected are hymenal lesions, followed by clinical findings relating to infections such as herpes blisters and abnormal vaginal discharge which lead to the suspicion of sexual abuse (unlike anal fissures which are not specific for abuse) [5].

Crohn's disease presenting as suspected sexual abuse is often misdiagnosed, although there are to our knowledge only five cases [6–8] reported in the literature. However, in contrast to all these cases our patient did not report any abdominal symptoms while showing severe inflammation of the terminal ileum.

Pathological findings on perianal examination, in particular anal lesions may heighten suspicion of sexual abuse. An assumption of sexual abuse, even if subsequently disproved, leads to emotional trauma in the patient and his or her family. Therefore Crohn's disease should always be included in the initial differential diagnosis of perianal disease and the threshold to perform endoscopy should be low.

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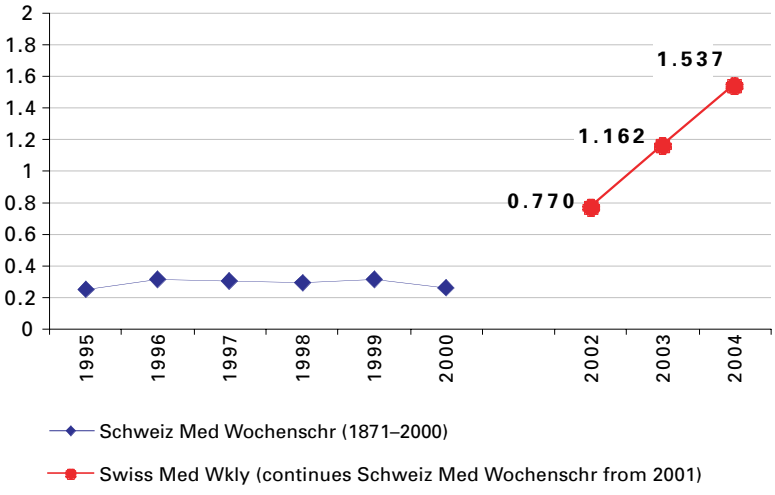

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