Don't Forget The Bubbles

GENITOURINARY SYMPTOMS IN YOUNGER CHILDREN

Learners Guide

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Topic: **Paediatric Genitourinary Presentations**
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Duration: **Up to 2 hrs**
Facilitator Level: **ST4 and above**
Learner level: **FY1 and above (can be adapted depending on the level)**
Equipment required: **A doll to demonstrate examination position and a willing volunteer to act as a concerned parent for a role play exercise.**

PRE-READING FOR LEARNERS

Expectation is for the learners to have understood the basics before the session. They should be encouraged to listen to the podcast and/or read the article below.

General Paediatric Gynaecology - 20 minute podcast
https://www.emrap.org/episode/emrap2019/pediatricpearls

Gynecology for the Paediatrician
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2791551/

OUTLINE (USE THE SECTIONS THAT ARE RELEVANT FOR YOUR LEARNERS)

- **Basics (10 mins)**
- **(2 x 15 minute) case discussion covering the key points and evidence including an optional practical session (10 mins) covering paediatric genital examination**
- **Advanced session: (2 x 20 minutes) case discussions covering more complex areas, diagnostic dilemmas; advanced management and escalation**
- **Quiz (10 mins)**
- **Infographic sharing (5 mins): 5 take home learning points**

We also recommend printing/sharing a copy of your local guideline (if available) for sharing admission criteria.

BASICS (DOES NOT NEED TO BE INCLUDED BUT FOR INFORMATION IF IT COMES UP IN DISCUSSION)

PAEDIATRIC GENITOURINARY PRESENTATIONS: SUMMARY

Paediatric GUM is an area that has the potential to cause significant distress to both parent and the child, it is often a clinical area in which clinicians feel underskilled and potentially embarrassed or uncomfortable.

Parents or carers may be very worried about the possibility of sexual abuse and Children and young people may feel anxious or embarrassed about discussing their symptoms and having to undergo a physical examination.

Clinicians may be anxious due to (often) a relative lack of training in this area and the potential sensitivity of the situation.

There are relatively few genitourinary symptoms - typically pain, discharge, bleeding and itching. The majority of cases will be due to mild self-limiting conditions such as vulvovaginitis but the clinician must always be aware of the possibility of more serious problems such as a retained foreign body or sexual abuse.

The underlying cause varies between age-groups because children become susceptible to specific conditions as they progress through childhood.

- Pre-pubertal girls have an oestrogen poor environment which leads to vaginal tissue that is more friable and sensitive than that seen in pubescent/post-pubescent girls. This makes them more susceptible to conditions such as vulvovaginitis.
- Sexually transmitted diseases - whilst sadly not unheard of in young children - are much more common in teenagers and should be high on the list of differentials in a young person who presents with gynaecological symptoms.
- Retained foreign bodies may occur in younger children exploring their bodies for the first time or in teenagers who are starting to experiment sexually.
- Straddle injuries are usually seen in nursery/primary school aged children - classically whilst attempting to climb out of a bath.
- Sexual abuse, whilst a comparatively rare cause of gynaecological symptoms should always be considered at any age - bearing in mind this may present differently in different age groups.

ASSESSMENT OF A CHILD PRESENTING WITH A GENITOURINARY PROBLEM INVOLVES:

• Using sensitivity and tact to elicit the history as always. However, we risk perpetuating stigma, shame and embarrassment if we take the history in a secretive or different way just because it involves genitalia. Care should be taken wherever possible to allow the child/young person to tell their story independently of the parents or carers. If there's any possibility of abuse in the history, the right person needs to be taking the first history as if there is any chance of a prosecution, the child needs not to be retelling the story and compromising evidence (and also minimising distress for the patient).

• Obtaining a comprehensive history including duration of symptoms, continence issues, precipitating factors and not forgetting more subtle signs such as change in behaviour.

• Exploring the concerns of the family who may be extremely anxious and come with preconceived ideas surrounding the diagnosis.

• Examining the child/young person (with an appropriate chaperone) to look for any obvious skin changes, discharge/bleeding or external signs of trauma. Aim to examine the child just once with necessary senior/specialist staff present and any equipment ready prepared in order to minimise distress. Appropriate use of a parent's lap and a play specialist are often invaluable.

• Considering the possibility of sexual abuse - including child sexual exploitation.

Referral for urgent assessment in secondary care should be considered if the child is:

• Presenting with a clear history of a retained foreign body
• Systemically unwell
• Actively bleeding
• Suspected of being maltreated.

Referral to the gynaecology team, if available, should be arranged (the urgency depending on clinical judgement) if:

• There is a suspicion of a retained foreign body.
• A child has symptoms that have failed to resolve with conventional treatment.
• There is uncertainty about the diagnosis.
• Examination under anaesthesia is likely to be required.

A child aged 3-10 years who presents with soreness and itching to the vulva/vagina is most likely to have vulvovaginitis. This can usually be safely managed in the ED/ UTC/primary care with advice and education for the child and family:

- Girls should be taught to wipe front to back after using the toilet
- Cotton underwear should be worn if possible
- Avoid wearing pants at night
- Salt water baths and nappy creams (eg Bepanthen or Sudocrem) may be helpful to ease the irritation
- Avoid bubble baths and sitting for a prolonged time in soapy water. Parents should be encouraged to wash the affected area in plain water.

Underlying conditions such as constipation, UTI or threadworm infection should be considered and treated where necessary. Vulval swabs may aid diagnosis of a bacterial cause, most commonly group A strep but remember skin commensal contaminants are common and the majority do not have bacterial infection.. Children whose symptoms are not resolving despite the above measures should be referred to secondary care.

Specific conditions that may be covered in more detail, depending on time available:

Vulvovaginitis - https://adc.bmj.com/content/archdischild/88/4/324.full.pdf

Straddle injuries - https://www.rch.org.au/clinicalguide/guideline_index/Straddle_injuries/

Retained foreign bodies - https://www.childrens.com/specialties-services/conditions/foreign-body
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3634203/

Child sexual exploitation - https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/child-sexual-exploitation/

CASE 1 (15 MINS)

Alysha is a very distressed six year old girl who attends A&E with her mother. She has blood in her pants following an accident in the park.

You find out that Alysha was on a family outing to the park. She was riding her big brother's bike and fell off, landing astride the crossbar. She has been complaining of severe pain to her vulval area since. There was a small amount of bleeding initially but mum thinks this has now stopped.

You explain that you will need to examine Alysha to assess her injuries fully. She is very frightened the examination will hurt and is refusing to cooperate. Her mother suggests that if you were able to demonstrate exactly what you need to do she may be more compliant.

Using a doll, demonstrate and explain to Alysha and her mother exactly how you will examine her. **What will you say?**

Alysha is now calmer and is happy for you to proceed but would like something to make sure it doesn't hurt.

What are your options?

After your fantastic preparation, the examination proceeds easily and you determine that there is minor laceration in between at the posterior fourchette on the right. It is not actively bleeding, there is no suggestion of urethral/clitoral damage and it does not encroach on the introitus.

You conclude that it is safe for Alysha to go home without any further intervention after she has passed urine in the department to be sure she is not at risk of urinary retention. Her mother would like some advice on how to manage at home and what to look out for.

What should you tell her?

CASE 2 (15 MINS)

Olivia, a 5 year old girl, is brought to the urgent treatment centre when her mother finds some yellow discharge with a streak of blood in her pants. Her mother has noticed she is 'scratching her privates' and is worried something might have happened to her at her new primary school.

What are the differential diagnoses in this case? How would you refine your diagnosis further?

A thorough history establishes that Olivia is systemically well but has been complaining of itching for the past three weeks. Since going to school she is no longer supervised to use the toilet and admits she only 'sometimes' washes her hands afterwards.

On examination you find that the vagina and labia are erythematous with a small amount of discharge. There is also some evidence of excoriation around the anus.

Given these findings, **what do you think is the most likely diagnosis? What will you do now and what advice will you give to the family?**

ADVANCED DISCUSSION (20 MINS PER CASE)

This is an opportunity to cover more complex areas, diagnostic dilemmas and advanced management and escalation if there are more experienced trainees or senior registrars in your group.

ADVANCED CASE 1

Inez is a 6 year old girl who is brought to ED by her parents with a two month history of vaginal discharge. They have seen the GP repeatedly and have been told that she is suffering from vulvovaginitis. Despite carefully doing everything their doctor recommended there has been no improvement in her symptoms and they are becoming increasingly frustrated.

How will you approach this case?
What are some of the differentials you will need to consider?

You manage to speak to Inez's GP who confirms she has seen her a number of times. Initially she was treated for simple vulvovaginitis but as it failed to improve she has sent vaginal swabs and urine MC&S. The vaginal swab grew a mixture of bacteria so Inez received a course of antibiotics which resulted in only a temporary improvement.

What symptoms might suggest a retained foreign body?
How might you proceed now?

ADVANCED CASE 2

Gabriella is a 3 year old girl. She attends the ED with her mother. Her mother is distraught and tells you that Gabriella was at her grandparents' house today while mum was at work. It's the school holidays and several cousins are at the grandparents house today including Brandon, the 13 year old great nephew of Gabriellas's stepgrandad who has never met Gabriella before. The grandparents rang her to pick up early as Gabriella would not stop screaming and was very very distressed after going inside to the toilet. Gabriella has told her mother that she doesn't like Brandon and he hurt her today. Gabriella is sad and withdrawn clearly in pain but clearly heard to say "he putted his finger in my bum and I don't like that".

How would you feel if presented with this scenario?

What are you worried about?

What are your next steps in managing this child?

CHILD SEXUAL ABUSE SIGNS
WE MUST KNOW

CHILDREN OFTEN SHOW US RATHER THAN TELL US THAT SOMETHING IS UPSETTING THEM. THERE MAY BE MANY REASONS FOR CHANGES IN THEIR BEHAVIOUR, BUT IF WE NOTICE A COMBINATION OF WORRYING SIGNS IT MAY BE TIME TO CALL FOR HELP OR ADVICE

58,000
CHILDREN NEEDED PROTECTION LAST YEAR

1in6
CHILDREN WILL EXPERIENCE SEXUAL ABUSE BEFORE THE AGE OF 16

SILENT ABUSE
OVER **90%** OF CHILD ABUSE IS CARRIED OUT BY SOMEONE YOU KNOW OR KNOWN TO THE FAMILY

1in3
CHILDREN NEVER TELL ANYONE & ARE KEEPING A FAMILY SECRET

WARNING SIGNS TO WATCH OUT FOR

Any one sign doesn't mean that a child was or is being sexually abused, but the presence of several warning signs suggests that you should begin to ask questions and consider seeking help

- NIGHTMARES AND SLEEPING PROBLEMS
- RESISTS REMOVING CLOTHES FOR BATHING OR CHANGING CLOTHES
- REGRESSING TO YOUNGER BEHAVIOURS LIKE BEDWETTING AND THUMB SUCKING
- PAIN DURING URINATION OR BOWEL MOVEMENT
- BECOMING WITHDRAWN OR VERY CLINGY, EASILY DISTRACTED OR DISTANT AT TIMES
- UNDERPANT SOILING ORBLEEDING UNRELATED TO TOILET TRAINING
- BECOMING UNUSUALLY SECRETIVE, TELLING LIES, REFUSING TO TALK ABOUT A SECRET THEY HAVE WITH AN OLDER CHILD OR ADULT
- SUDDEN UNEXPLAINED PERSONALITY CHANGES: RAGE, INSECURITY, ANGER, DEPRESSION AND ANXIETY
- NEW WORDS FOR PRIVATE BODY PARTS AND NO OBVIOUS SOURCE
- UNACCOUNTABLE OR NEW FEAR OF PARTICULAR THINGS, PLACES OR PEOPLE, NOT WANTING TO BE ALONE WITH A PARTICULAR PERSON, EVEN SOMEONE YOU KNOW AND TRUST
- CHANGES IN EATING HABITS, TROUBLE EATING OR SWALLOWING
- ACTING OUT IN AN INAPPROPRIATE SEXUAL WAY WITH TOYS OR OBJECTS, PLAYING SEXUAL GAMES
- TALK OF NEW FRIEND, AND UNEXPLAINED MONEY OR GIFTS
- SELF-HARM CUTTING, BURNING OR OTHER HARMFUL ACTIVITIES
- CHANGES IN CLOTHING, DRESSING SHABBILY OR IN SOME INSTANCES DRESSING PROVOCATIVELY
- PHYSICAL SIGNS, SUCH AS: UNEXPLAINED SORENESS OR BRUISES AROUND GENITALS OR MOUTH, RASHES, BLEEDING, HAIR LOSS AND BRUISING OR BITE MARKS TO BODY
- RUNNING AWAY FROM HOME, FREQUENT SCHOOL ABSENCES, ACTING OUT IN SCHOOL, NOT WANTING TO PARTICIPATE IN PE, SPORTS AND SWIMMING

OVER **90%** OF SEXUAL ABUSE IS PREVENTABLE

THROUGH BETTER AWARENESS AND ABUSE PREVENTION EDUCATION

REMEMBER THAT ABUSE HAPPENS TO BOTH **BOYS AND GIRLS**

ABUSE AFFECTS
CHILDREN FROM ALL SOCIAL CLASSES, RELIGIONS AND ETHNICITIES

AROUND **50% OF SEXUALLY ABUSED** CHILDREN SUFFER MENTAL HEALTH PROBLEMS

Suspect abuse with someone else's child

IF IN DOUBT, **REPORT!**

WHAT SHOULD I DO IF I BELIEVE A CHILD IS IN DANGER

FOR IMMEDIATE RISK CALL	IF YOU'RE AN ADULT WORRIED ABOUT A CHILD CALL NSPCC	IF YOU'RE A CHILD & NEED TO TALK CALL CHILDLINE
POLICE ON **999**	HELPLINE **0800 800 5000**	**0800 1111**

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QUIZ QUESTIONS (10 MINS)

Question 1.

Which of the following is NOT typical of vulvovaginitis?

A. Vaginal itching
B. Offensive discharge
C. Vaginal soreness/discomfort
D. Erythema
E. Dysuria

Question 2.

When managing a straddle injury, laceration involving which areas would you likely feel confident managing without need for gynaecology referral?

A. Labia minora, clitoris and urethra
B. Labia majora, minora and introitus
C. Clitoris, introitus and Labia minora
D. Labia minora, majora and posterior fourchette

Question 3.

In a straddle injury, what form of analgesia may be appropriate?

A. Entonox
B. Diamorphine
C. Simple analgesia
D. Ketamine
E. All of the above

Question 4.

Which of the following does NOT exacerbate vulvovaginitis?

A. Urinary tract infection
B. Bubble bath
C. Threadworm
D. Obesity
E. Synthetic underwear

Question 5.

Which of the following statements are TRUE?

A. Child Sexual Abuse only happens to vulnerable young people eg those in care.
B. If a young person consents to sex then it is not a crime.
C. There will usually be obvious signs that a child is being abused.
D. CSE can happen on line as well as in person.
E. A child may be being exploited even if they feel they are in a loving relationship.

Finish

1. infographic of the take home tips (5 mins)
2. Good preparation is key to a successful examination.
3. In cases with offensive or blood stained discharge consider a retained foreign body.
4. The majority of straddle injuries involve bruising/lacerations to the labia. These will usually heal well with conservative management.
5. CSE can be difficult to spot but an index of suspicion should be maintained when dealing with young people who present with genitourinary symptoms.

References

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Foreign body
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Straddle injury

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CSE

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Vulvovaginitis

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Key Papers

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