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BRIEF COMMUNICATION

SYPHILIS AS A SOLE INDICATOR OF SEXUAL ABUSE: TWO CASES WITH NO INTERVENTION

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THE DIAGNOSIS OF SEXUAL ABUSE is being made with increasing frequency. This is due mostly to increased disclosure, combined with the recognition that children do not usually lie about such matters. However, in the absence of a history, there may be other indicators of sexual abuse such as certain traumatic physical findings, or the presence of a disease known to be almost always sexually transmitted. In these cases, it is often more difficult to offer adequate protection to the victims.

The Center for Child Protection (CCP) of the Children's Hospital and Health Center in San Diego has seen two cases of secondary syphilis since 1979, during which time over 6,000 children have been evaluated for sexual abuse. In both of these cases, the medical practitioners and social agencies developed significant differences of opinion. The workers from the social agencies felt that, in the absence of a history, the medical evidence was insufficient and closed the cases. The medical team involved in these cases felt that secondary syphilis is a certain indicator of sexual abuse and were uncomfortable with this outcome. These cases are presented in the hope of stimulating discussion about the problem encountered when social agencies and courts are charged with decisions based only on medical evidence.

CASE HISTORIES

Case 1

A 5-year/10-month-old Samoan female was referred to the CCP from the emergency department of a local hospital with the diagnosis of venereal warts. She had been seen four months previously at the same department for lesions in the genital area, at which time a diagnosis of dermatitis was made, and she was treated with ampicillin at a dose of 125 mg q.i.d. for one week. This was sufficient to cause temporary complete resolution of the lesions, but they returned several weeks later. She was again brought to the emergency department, complaining also of pain on urination and

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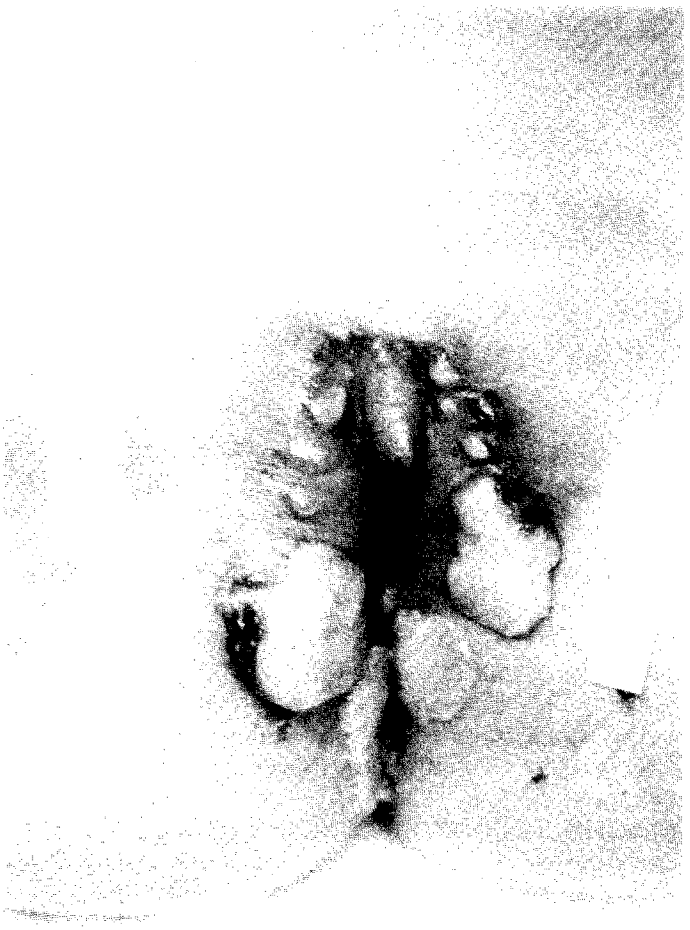

Figure 1. Acquired syphilis in 5-year/10-month old with irregular, heaped, erythematious weeping lesion.

defecation. The case was reported to the agency responsible for child protection in the county, and she was referred to the Center for Child Protection for an evidentiary examination and interview for possible sex abuse.

The description on her CCP record of the findings were of "irregular, heaped up, erythematious, weeping lesions extending from the clitoris to the anus" (Figure 1). The rest of the exam was entirely negative. No history of sexual abuse was obtained on questioning. Suspicion of secondary syphilis was raised because of the appearance of the lesions and the history of partial response to ampicillin. A decision was made to admit her to Children's Hospital to obtain a definitive diagnosis. A serologic test for syphilis (RPR) and darkfield of the lesions were ordered at this time. Gonorrhea cultures of pharynx, rectum and vagina were also done.

On the second hospital day, the RPR and darkfield examination were both reported as positive and she was treated with 2.4 million units of Bicillin. Gonorrhea cultures were negative. She was released five days later with almost complete resolution of the lesions. She repeatedly denied any sexual abuse, and it was decided by Child Protective Services to send her to a foster home. Living in her own home at the time were her 22-year-old mother, two half-siblings, her mother's four siblings, which included a 14-year-old sister and three brothers, aged 17, 19, and 20. RPRs were done on the entire family, and the child's 17-year-old uncle tested positive. The family made no attempt to remove him from the home, and the child remained in foster care for one month, at which time she was returned home.

A new referral on this child was made to Child Protective Services from her school six years later because of her difficulty adjusting and because of prolonged crying episodes. Because of a lack of history from the child, the case was again closed.

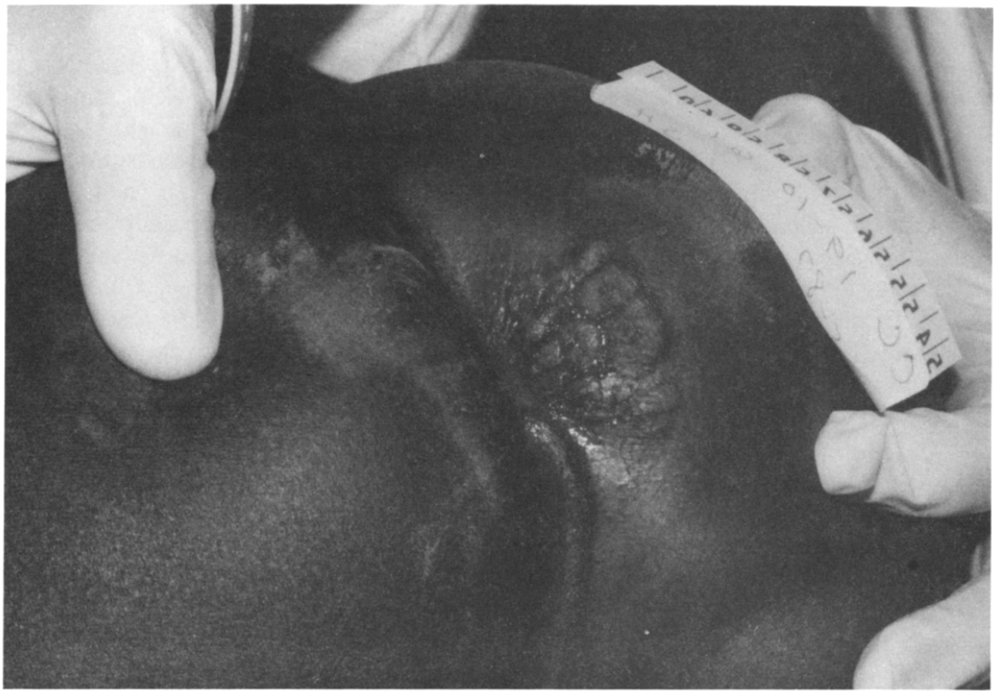

Figure 2. Acquired syphilis in a 5-year/6-month old with raised, flat, irregular lesions.

Case 2

A 5-year/6-month-old black male was referred to the CCP because of a positive serologic test for syphilis (RPR) obtained by his pediatrician. He had been seen by his pediatrician two months earlier for lesions around his anus. At this time the rest of his exam was negative, as were cultures of the pharynx, rectum, and urethra for gonorrhea. The diagnosis was made of venereal warts, and the case was referred to the child protection agency. The case was dropped after interviews with the child and his parents failed to elicit any information about sexual abuse. Other factors affecting this decision were that the parents seemed "appropriate" and the thought that possibly the child's lesions could have been transmitted from warts on his hands or might have been present from birth. The child was treated with podophyllin without response, and then referred to a dermatologist. A serologic test for syphilis was obtained at this time and reported as positive. He was then treated with 2.4 million units of Bicillin and was again reported to the child protective agency as well as to law enforcement. Law enforcement authorized an examination and interview at the CCP.

On physical examination, the lesions were described as "raised, but with a flat, somewhat irregular surface, almost rectangular in shape, and of a brown-gray color" (Figure 2). The diagnosis of condylomata lata of secondary syphilis was made and later confirmed by biopsy.

The child gave no history of sexual abuse to the social worker at the CCP. This social worker's opinion was that the denials were believable. His parents again seemed appropriate. He was sent to his grandparents' home by the child protection and law enforcement agencies. The parents were tested for syphilis, and the mother was found to be positive, while the father tested negative. An adult male who had lived with them for a time was contacted and denied a history of syphilis. He did reveal to the police officer that there was a significant amount of drug trafficking in the home and that the mother had several sexual partners. He also said that the boy and his mother slept in the same bed. The mother denied any sexual contacts other than her husband. At the readiness hearing at which representatives from the child protection agency and the juvenile district attorney's office were present, it was decided that there was no protective issue involved. The boy was returned to his parents, and the case closed. Review of case records from the child protection agency indicated that contact was made with the Center for Disease Control in Atlanta. The representative responding cited a small possibility of asexual transmission of syphilis. This potential was thought to be the probability in this case, with the disease having been contracted by the boy from his mother in a nonsexual manner.

Reports of Noncongenital Syphilis

Few recent reports on noncongenital syphilis in children could be found in the literature, although there are many reports of other sexually transmitted diseases in children. In one report, there were six cases of syphilis in a child sexual abuse clinic, all of which were assumed to be sexually transmitted (White, Loda, Ingram, & Pearson, 1983). Another report from an acute care clinic cited three prepubertal children with syphilis seen for rashes. These were also presumed to be sexually transmitted (Ginsburg, 1983). One case of asexually transmitted syphilis is described with transmission from a breast lesion of a nursing mother to her infant son's right ear which was in direct apposition to the lesion while nursing (Arulenantham, 1978). For further reports of syphilis in children, we had to turn back to the first half of this century (Smith, 1939; Waugh, 1978). In these reports, transmission is attributed to varying routes, from sexual intercourse to "trumpets and toys, especially when purchased from common street vendors" (Waugh, 1978).

DISCUSSION

Despite a clear expression of opinion by physicians at the Center for Child Protection that these two children had acquired syphilis through sexual contact, child protective service workers closed the cases. In the second case, additional medical opinion was sought, and when a small possibility of nonsexual transmission was acknowledged, this was used as a basis for the CPS decision. What the reasoning was in the closing of the first case is unclear.

Had these cases not been closed, other steps could have been taken that might have elicited a history, in addition to providing protection for these children as well as others who might have been at risk. Possible avenues of pursuit of these cases included involving the children in therapy where an atmosphere of safety more conducive to disclosure might have been achieved, and coordinating efforts with the health department might have resulted in finding other positive contacts of the uncle and mother in these cases of syphilis. Further investigation of these cases might have led to finding more children with syphilis, as yet undiagnosed, who had also been sexually abused.

Cases such as these, where there is medical evidence of abuse and no history is forthcoming, need very careful surveillance until the situation is clarified and appropriate measures can be taken. These children, who are unable to disclose the circumstances of their abuse, may be those most in need of protection.

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