

SECTION 1

Prepubertal girls

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Initial assessment

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Infants are ideal patients. The first gynecologic exam should occur in the nursery, when the patient is the most co-operative. Obviously, what can be described at that time is the anatomy and patency of the system.

The primary care provider, who will form a relationship with the child and family over time, is the ideal person to perform routine gynecologic assessments, including inspection of the external genitalia in the context of a routine physical exam. Making the genital exam a part of the general physical exam dispels forbidden boundaries and provides an opportunity for education about normal anatomy and hygiene, and discussions of body changes, when appropriate. It is also a time to open discussions about accurately identifying body parts in order to relieve their stigma. Although parents and children should be having age-appropriate discussions about sexuality during the prepubertal years, specialist expertise may be needed on occasion.

The most common presenting complaints of the genital area in the infant and prepubertal child concern anatomy and development, labial agglutination, dermatologic issues, itching and discharge, bleeding, and sexual abuse. In order to evaluate and diagnose the prepubertal child, you need to take a problem-focused history and perform a physical exam while allaying anxiety and fears.

History

The history is best taken while the child is comfortably dressed in her own clothes. It is always good to

★ Tips and tricks

- Make no mistake, a successful visit with a young child requires the provider to dispel some assumptions – a child is not a small adult and the provider is not in total control. The patience, flexibility, and playfulness of the clinician are keys to engaging and examining the prepubertal child, a challenging undertaking that, when successful, is very rewarding.
- Inspection of the external genitalia should be a routine part of a general physical exam.
- The history is best taken while the child is comfortably dressed in her own clothes.
- When it comes to the physical exam, it is imperative to explain to the child what you will be doing in a way that she can understand. It is always good first to do a general exam, including height and weight, as going straight to the genital area, which may not have been examined before, may appear threatening.

☞ Caution

If the provider has a question about sexual abuse, it should be asked before proceeding to the physical exam so as not to create a situation in which the parent/caregiver assumes that the provider saw something to initiate the question.

talk to the child in an age-appropriate way and to note and comment on something personal, like her shoes, dress, barrette, or a security toy that she brings. Obtaining any history from the child and parents about masturbation or infections in the family, such as Strep or pinworms, can be helpful.

You should find out when the presenting problem started and whether it is persistent or intermittent. Has anything been tried to treat it, and did this help? If concerns about sexual abuse have been expressed, ask about any behavioral changes that have been noted, such as sleeping problems, bedwetting, abdominal pain, or inappropriate acting out. If the complaint is vaginal bleeding, it is important to find out about growth and development, trauma, odor or previous history of a foreign body. Actually asking the young girl directly if she has ever put anything in her vagina can be revealing. Finally, it is important to obtain a history for any exposure to hormonal creams or patches.

Taking a history also provides an opportunity to describe normal and anticipated changes and to answer questions. At the end of the history, it is good to ask if the parent or child has any questions.

Physical exam

When it comes to the physical exam, it is imperative to explain to the child what you will be doing in a way that she can understand. It is always good to first perform a general exam, including height and weight, as going straight to the genital area, which may not have been examined before, may appear threatening. Children are comfortable and familiar with their chests and hearts being listened to and their tummies examined. Give the child choices: not whether or not she will get undressed, but what gown to wear and whether she wants to sit on the table or stay in her parent's lap. It is also good to introduce the light and gloves as things you will be using and allow the child to touch and play with them a little. If you will be using a colposcope, allowing the child to look at something through the scope can demystify the experience. Moreover, the pace of the exam is important: if you rush the child, you can forfeit her co-operation.

Reinforce, particularly to the parents, that you will not do anything to change the anatomy and that

mostly you will just be inspecting the anatomy without inserting any instruments. It is important to state clearly that the exam will be painless.

The physical exam also provides an opportunity to look for any nongenital skin problems, pigmentation, breast development, hernias, or signs of early puberty, which may explain the presenting complaint.

Then, depending on how the child is doing, you can give the child a description of the choice of positions you would like her to take: butterfly, frog, or lying on mom or dad on the table, in or out of stirrups. Children familiar with horse riding may choose the stirrups. Once the child has chosen a position, simple inspection without touching can reveal lichen sclerosis or evidence of a previous or current vulvovaginitis or excoriations, and the clinical question may be answered. Always inspect the anal area for lesions or excoriation.

You should always identify the anatomy carefully, even if the presenting complaint is an obvious skin condition, because the child may have an additional problem, such as imperforate hymen, that has not been previously noted.

In order to examine the genitalia further, it is important to desensitize the child by first touching her legs and then maybe her inner thighs with your gloved hand. Engaging the child to use her own hands to assist you can be very helpful. They sometimes like to put gloves on as well. Sometimes gentle retraction laterally and downward can reveal labial agglutination or provide a better view of the anatomy, including the clitoris, urethra, and hymen. If you cannot define the anatomy of the hymen, retracting the labia gently forward and asking the child to cough can open things up further. When the vagina is visible, sometimes the clinician can see a discharge or can smell anaerobic organisms. The vagina may be estrogenized or there may be clear hygiene issues.

You can sometimes make a game of placing the child in the knee-chest position (on her knees with her shoulders on the table and bottom up in the air). Spreading her legs and gently spreading the labia can allow you to look up into the vagina for evidence of discharge or foreign bodies such as toilet paper. Before doing this, it is important to tell the child that you are not going to put anything into her bottom and to show her the light you will use. Getting the child to “pant like a puppy” or cough also can help to relax the vagina.

You always need to be particularly sensitive if the child has been sexually abused or had other exams that that did not go well. If, for instance, someone has previously tried to do a vaginal culture with a standard swab used for throat cultures, it is almost impossible to convince a child that the tiny Calgiswab you are going to use is different. Getting her to cough (which distracts the child and can also relax the hymen and open the vagina) and not touching the hymenal ring usually provides a very good vaginal (as opposed to vulvar or vaginal vestibule) culture.

Caution

If, after following these suggestions, the visit is not going well and the problem is not acute, you will save your relationship with the child by suggesting simple common solutions to the problem (e.g. hygiene, topical “butt creams”, changes in clothing and sleep wear, etc.) and scheduling a future visit.

It is important to praise the young child constantly for what a good job she is doing. This is an exam for which you should allow extra time if needed. If the child becomes upset, a time out for everyone to regroup can salvage the appointment that day. If things do not go well, it is still important to identify and acknowledge something that the child did well. Sometimes parents become very frustrated and angry because they have taken time off work for the visit and just want to fix what is going on. It is critical that the child not be punished if she has tried her best, even if it does not work. Sometimes it is best to

schedule another visit when the child has eaten or is not tired after school.

Caution

Depending on the urgency of the complaint and the need to obtain an adequate exam sooner rather than later, an exam under anesthesia may be required. However, for most nonacute issues, if you cannot accomplish what is needed at the first visit, you can schedule a follow-up visit; on the second occasion the child may be more familiar with the office.

Working with children is not only a challenging but also a humbling experience, especially for those of us who usually like to be in control. A good visit can be very satisfying, but sometimes, in spite of all our best intentions, patience, and planning, we may not accomplish everything that was requested or that we set out to do during a visit. The clinician will inevitably develop their own unique approach and personal tricks for success. Do not be afraid to act a little like an adult child. Children have a radar for honesty and caring. Making the first experience a good one lays the groundwork for future success for everyone.

Further reading

Emans SJ. Office evaluation of the child and adolescent. In: Emans SJ, Laufer MR, Goldstein DP, eds. *Pediatric and Adolescent Gynecology*, 5th edn. Philadelphia: Lippincott Williams & Wilkins, 2005.