NATIONAL CHILD PROTECTION GUIDANCE

APPROVED: December 2021

Title:	**Assessment and Management of Genital Bleeding in Pre-Pubertal Girls**
Version:	1.1
Review Date:	1st December 2023.
Target Audience:	All medical and nursing staff in the Emergency Department, all paediatric wards and Community Child Health. All primary care and community based staff working with young infants and babies.
Keywords:	
Shared MCN Guidance:	This guidance has been produced with the support of the three managed clinical networks for child protection in Scotland. The guidance represents the key considerations that health boards could reasonably be expected to provide support for. Each guidance document is primarily to support clinical care and is designed to be modified by individual boards or centres with local contact information, investigation sets and/ or clinical systems information.

Introduction

This guideline is to support the clinical assessment and management of prepubertal girls presenting with vaginal bleeding.

'Vaginal' bleeding can be an alarming presentation for children, parents and health professionals as Child Sexual Abuse (CSA) is often considered. It is NOT a common presentation of CSA, and other more common paediatric skin, traumatic or medical conditions should be part of the differential diagnosis and assessment.

It is important to take detailed history from parents and carers, and examination of the child and (if possible underwear) will aid assessment. It is important to clearly document that CSA has been considered.

Causes of Bleeding

Age of the child is important. Baby girls can have vaginal bleeding as a physiological response to maternal hormones in the first few weeks of life. Urate crystals can also present with pink staining in the nappy which can be mistaken for blood. It is important to remember that CSA can co-exist with defined medical causes of genital bleeding (See Table 1).

Table 1: Causes of Genital Bleeding in Pre-Pubertal Girls
Common • Constipation/anal fissure • Vulvovaginitis is common but can be difficult to pick up. History is important (see below- Table 2) • Lichen sclerosis • Accidental Trauma: ie straddle injury- this is usually associated with external genital bruising • Threadworms • Infections: Can be transmitted by poor hygiene and lack of handwashing (auto inoculation) or from sore throat (strep, haemophilus often isolated on swab) • No cause found
Less Common • Foreign body: Remember prepubertal children explore their genitalia often, and can put FB into vaginal orifice so associated with ongoing symptoms and discharge. Repeated self-insertion of foreign body can be a sign of CSA. • Sexual abuse • Isolated Menarche: no other signs of puberty • Separation to labial adhesions – mechanism needs explored through history • Urethral prolapse
Rare

- Tumours
- Recent Female Genital Mutilation
- Fabricated or Induced Illness
- Sexually transmitted infection
- Bleeding disorder

History

Ano-genital bleeding often presents as blood on the child's underwear and is the clinician's task to determine the source of the blood. Bleeding reported by the child or parents as "vaginal" may be vaginal, or from the skin, urinary tract or anus.

Remember to ask older children for their account of the cause of the bleeding.

Important areas to explore in history include:

1. Is this blood? (i.e. urates)
2. Is this coming from the vagina/urethra/anus?
3. Bleeding: Quantity, duration, recurrence, any other site?
4. Pruritis: night time pruritis may indicate threadworm infestation, vulvovaginitis, lichen sclerosis or eczema
5. Trauma: ie straddle injury, exact description of event? Has this been witnessed and by whom? This must be documented. Does this fit with the mechanism of injury?
6. Bowel habit: Constipation and anal fissure can present with bleeding, inflammatory bowel disease
7. Urinary symptoms: Dysuria, frequency, ie Haemorrhagic UTI, stones
8. Pubertal history – or any signs of precocious puberty

9. Associated foul smelling or bloody vaginal discharge: foreign body, necrotic tumour, vaginitis.

10. Family history of bleeding disorders

11. CSA flags: Disclosure/care-giver concerns, contact with known abuser, sexualised behaviour, Child Protection Register, behaviour changes, child sexual exploitation risk factors, parental concern. Consider recent FGM.

Examination

Full examination with consideration of pubertal status should be undertaken with particular attention to signs indicated in Table 2. Consider other signs of bleeding disorder such as petechiae, bruising, haematomas.

It is important that the genitalia and surrounding area are visualised in all cases and this examination is documented.

Table 2: Anogenital Examination Please refer to Appendix 1: Anatomy of the Pre-Pubescent Genitalia
• Redness, erythema, signs of inflammation ? vulvovaginitis. • Any eczema? Scratch marks? • Lichen sclerosis - bruising , blood blisters, itchy and painful skin lesions and pale skin around the vulva, perineum (figure of eight) • Obviously visible threadworms • Visible discharge? • Other signs of trauma – bruising, abrasion documenting the site- does this correlate with the mechanism described? • Visible foreign body? • Labial adhesions?

Discuss cases with senior colleague or document rationale for not taking this action.

Investigations

This will be informed by History and Examination (see Table 3).

Table 3: Investigations of Genital Bleeding in Pre-pubertal Girls
The following investigations should be considered: • Urine - dipstick/M,C & S • Bloods - FBC, coag, extended clotting, U&E, LFT • Bloods – hormone profile (it is recommended these investigations are discussed with local endocrinology specialists and could include GnRH/thyroid function tests). • Ultrasound pelvis/abdomen • Vulval swab if discharge or local erythema

Referral for Colposcopic Examination

Colposcopy will be appropriate for a few children with genital bleeding but this needs to be discussed with a senior colleague who should decide if further discussion is required with the on call Child Protection Team. Any child who has disclosed CSA should be automatically referred to the Child Protection Team. If there are any concerns about acute CSA, advice and support can be sought early from the Child Protection Team so that early evidence swabs and co-ordinated examination can be arranged.

If a child presents with historic sexual assault (>7days ago) or suspicion of female genital mutilation please refer to the Child Protection Team (Local Details).

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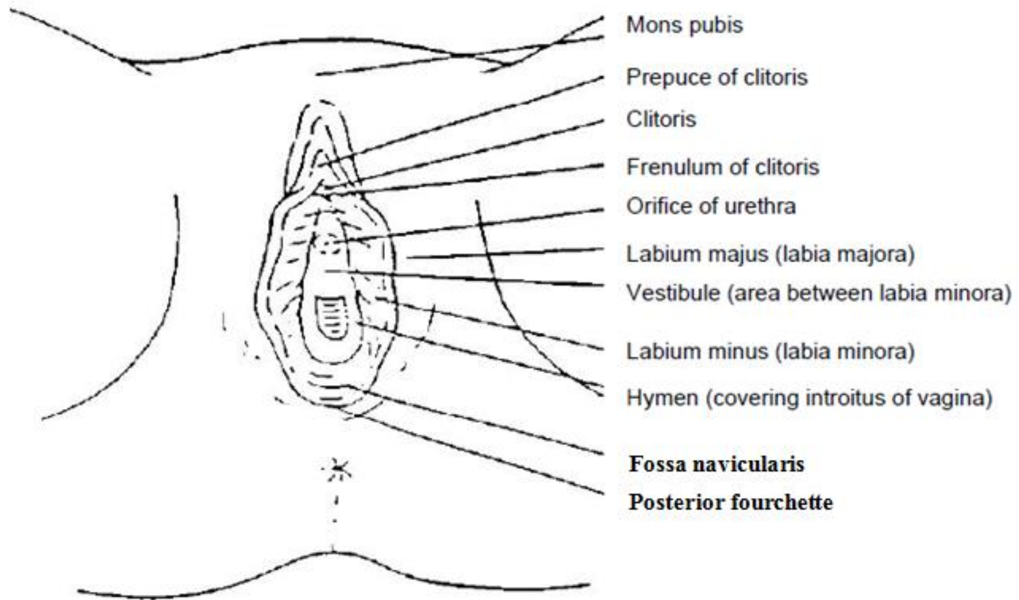
Appendix 1: Line Diagram Of Pre-Pubescent Female Genitalia



Appendix 2: Flow Chart Investigation of Genital Bleeding in Pre-Pubertal Girls