MEDICAL

GUIDELINES FOR HIV TESTING OF SEXUALLY ABUSED CHILDREN

—by Martin Finkel

The following guidelines were developed based on the experience of Dr. James Oleske, Director of the Division of Allergy, Immunology and Infectious Disease at the University of Medicine and Dentistry of New Jersey, New Jersey Medical School. Dr. Oleske is a nationally recognized authority and clinical pioneer in the treatment of AIDS.

Many clinicians working with children alleged to have been sexually abused are looking for criteria on which to base their decisions regarding whom to test for AIDS and how often to retest. I asked Dr. Oleske for his perspective on this issue. I hope his recommendations will trigger a response from other clinicians.

Please provide your institution's clinical perspective on this issue by writing to Martin A. Finkel, DO, Associate Medical Editor, APSAC, UMDNJ-SOM, Dept. Pediatrics, 301 S. Central Plaza, Suite 2100, Stratford NJ 08084. Responses will be published in a subsequent issue of The Advisor, in hopes of stimulating further discussion.

Should sexually abused children and adolescents be screened for HIV antibody, and if so, what studies should be performed and when should they be repeated?

Conservative estimates indicate that over 200,000 children are sexually abused each year in the U.S., and that over 20% of all children may be sexually abused before they reach adulthood. The rate of HIV infection in the U.S. is expected to be simlarly high. By 1991, from 3 to 13 million Americans (1% - 5% of the total U.S. population) may be HIV infected.

Our experience in Newark, New Jersey reflects that the incidence of HIV among heterosexuals is rising. Prior to 1984, 15% of women who had AIDS got it through heterosexual activity; by 1988, that number had increased to 45%.

Should all children alleged to have been sexually abused be tested, or only some? No prospective data document the actual risk of transmission of HIV by sexual abuse. Clearly, however, the abused individual's exposure (rectal, vaginal, or oral) to semen or other HIV positive body fluids is a prerequisite for HIV transmission: children known not to have experienced such contact can be assumed to be safe.

Further sorting of abused children who have come into contact with semen could be made on the basis of the severity of their physical trauma: the greater the trauma, the higher the chance of transmission, and the more important the HIV test.

But until we know more about transmission, deciding to test or not to test based on the severity of physical trauma is not advisable. Although broken skin increases chances of transmission of the AIDS virus, broken skin is not a necessary condition of transmission. Of 15 children and adolescents who were sexually abused by a perpetrator known to be HIV positive, three who were tested in our program became HIV positive.

The history alone is unreliable too in determining whether or not the child has come in contact with body fluids that may be HIV positive. Accurate details concerning the type of abuse experienced is not available from all sexually abused children.

Surely it is better to err on the side of safety. Every sexually abused child or adolescent, as well as the alleged perpetrator, should be screened for HIV at the time the assault is reported, and again at three and six months. Testing should be done after six months only if any symptoms of HIV infection occur.

Screening at these intervals is indicated because the latent period between infection and development of positive serological response is usually three months, although a one-year delay in development of antibody has been rarely reported. (The incubation period for the onset of symptoms of HIV infection may be as long as seven to ten years.)

Universal testing is recommended in part because assays testing for both antibody and antigent to HIV-I have improved our diagnostic accuracy. False positive screening ELISA assays that reduce the positive predictive values in low risk the patient's true HIV status determined in most cases by these newer HIV assay systems. People are identified as HIV infected if they produce a Positive ELISA HIV Ab assay confirmed by either Western Blot/immunofluorescence Ab assay or with culture evidence of viral infection.

Universal testing is recommended also because presently constituted sexual abuse clinics usually have appropriately trained medical and social staff to economically add HIV testing and counseling to those tests now being performed on abused children and adolescents.

Finally, universal HIV testing of sexually abused juveniles and their alleged abusers is recommended because the sooner infected individuals are identified, the sooner they can be helped. Both the quality and the length of HIV patients' lives have gradually improved with comprehensive support programs and the use of the antiviral drug AZT. Individual education regarding prevention of spread and available health care can only be effective when an individual is identified as being HIV infected.

Fear and confusion still abound regarding HIV testing because of past stigmatization of HIV infected individuals. Unfortunately, this has inhibited appropriate public health responses to this disease. All individuals at risk for developing HIV should be tested and given appropriate counseling regarding test results. Those individuals identified as HIV positive should receive compassionate health care and sound public health advice and counseling. They should be given access to all new treatment programs, and be spared stigmatization and loss of civil rights. We must all fight irrational fears in ourselves, our colleagues, and the general public, and watchdog legal and moral issues surrounding this disease.

Finally, we should seek funding for multicenter projective studies to define the exact magnitude of HIV infection in sexually abused children and adolescents.

Martin Finkel, D.O., is Associate Professor of Clinical Pediatrics at University of Medicine and Dentistry of New Jersey, and ***The Advisor's*** *Associate Medical Editor.*