Management of Childhood Sexual Abuse

Donald P. Orr, MD
Orange, California

Childhood sexual abuse is increasingly recognized as a major problem in the United States. These children are frequently seen by the primary care provider, and physicians must be able to evaluate them. Common presentations for sexually abused children include direct allegations, suspicions by the caretaker, unexplained vaginal trauma or bleeding, sexually transmitted disease, and a wide spectrum of behavioral problems including sexual promiscuity and runaway behavior. The interview and physical examination must be performed in a quiet, private area and sufficient time allocated to allow a thorough evaluation. All sexual abuse must be reported to the local child abuse authorities. Any abnormalities must be carefully described and treated. Evidence collected should be handled according to a protocol and given to authorities. Postexamination counseling should include explanation of findings, legal implications of sexual abuse, and anticipatory guidance about common psychological sequelae of abuse.

The primary care physician who treats children is likely to encounter childhood sexual abuse, since Finkelhor estimates that at least 19 percent of college age women and 8 percent of men have been sexually victimized as children.[1] Despite a growing awareness that sexual abuse of children is a widespread and serious problem,[2] the role of the physician in the treatment of abused children is not yet clearly delineated. Physicians perform poorly in the evaluation of these children[3] and frequently fail to report cases of suspected sexual abuse.[4] The reasons for this failure are complex: some are undoubtedly related to anxiety and feelings that are aroused by the examination itself and some are due to a general aversion to the problem of sexual abuse and lack of sufficient information and education on the part of the physician. Most of these problems can be solved so that the children can receive sensitive medical care that yields factual and relevant information.[5]

With the realization that male and female sexually abused children may have been subjected to a spectrum of offenses from fondling to oral-genital contact to actual intercourse,[6] it becomes apparent that the initial evaluation must be comprehensive and include a detailed history, physical examination, treatment of identified medical problems, and collection of evidence, insofar as these are possible.

Up to 35 percent of girls[5] and 50 percent of boys[7] examined for alleged sexual abuse may have physical findings suggestive for abuse. Every child who is brought to a physician with a suspicion of sexual abuse requires a complete evaluation, including genital examination. With sensitive handling and patience, the majority of children can easily be examined without apparent psychological trauma. Omission of the genital examination as unnecessary or unhelpful is no longer justified.

This paper describes a plan to manage sexually abused children when they present to the primary

From the Department of Pediatrics, Adolescent Program, University of California Irvine, Orange, California. Requests for reprints should be addressed to Dr. Donald P. Orr, University of California Irvine Medical Center, 101 City Drive South, Orange, CA 92668.

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care physician. It can be used by any physician, regardless of specialty training.

Physician Requirements

The primary requirement for the physician is an interest in the well-being of children and a willingness to serve as the child's advocate. This must include testifying in court, if required, and sufficient patience to tolerate the complicated social, legal systems in which these children and their families become enmeshed. If the physician feels that he/she cannot afford the time and inconvenience, the best way he can serve the abuse victim is immediate referral to a Child Abuse Center which has demonstrated the ability to manage sexually abused children. These are usually located in teaching hospitals. The National Center for the Prevention and Treatment of Child Abuse and Neglect can provide their locations.

Other requirements are: (1) the ability to relate to children and interact with them sensitively and with empathy. This is more important than the possession of specific gynecological credentials, since any examination will be impossible to carry out without the cooperation of the victim; and (2) a competence to carry out a genital examination and collect and document physical evidence. These skills should be possessed by all primary care physicians.

Once the physician understands the spectrum of sexual abuse and can handle the feelings which arise in him as a consequence, the examination becomes relatively straightforward because to a large extent the complexity of the examination depends on the patient's history. The genital examination and collection of evidence is only one small part of the comprehensive evaluation of sexually abused children, and gynecological consultation can always be secured in the few instances where it is specifically required.

Role of the Physician

It has been suggested that one source of confusion in the initial evaluation of sexually abused children relates to confusion about the exact role of the physician.[3] This results in anxiety and a reluctance to become involved. The issues involved in sexual crimes, particularly those against children, are complex and it is mandatory that evaluation and treatment involve a multidisciplinary approach. The physician must be a member of a team that is sensitive to the specific needs of these children and can expedite the victim's movement. Other members of the team should include a social worker (who may be from the local department of social services or child protective service), and police and court officials when legal action is taken. Mental health treatment should be available in the community. Thus the physician in private practice can effectively manage the children by utilizing existing community resources. If these children are examined in a hospital emergency room, it is mandatory that the hospital have a protocol for a speedy registration and examination to ensure a rapid, thorough, and uniform evaluation (the University of California Irvine Medical Center administrative protocol is available on request).

A realistic role for the physician includes the following:

1. Comprehensive medical and initial psychosocial evaluation of the child at the time of presentation. The physical examination should include the collection and handling of any specimens for evidentiary purposes and the treatment of any medical conditions related to the abuse incident.
2. Report of the abuse as required, and assurance, as far as possible, that the child is in a safe environment. This may include temporary out-of-home placement by the local mandated authorities. At times the physician must insist that this action be taken.
3. Hospitalization of the victim, if required.
4. Follow-up of the child and family to treat any medical conditions and to assess the immediate reactions to the reporting of the event, provision of emotional support for the child, and assurance that the social case work and legal processes are functioning. He may delegate this function to other team members but must be ultimately responsible for its implementation.
5. Continued contact with the agencies that provide services to families when child sexual abuse occurred. This may include testifying in court. Although the physician is often the first person to treat the child, he is a member of a larger team. Psychological treatment is not to be provided by him alone, particularly in the incestuous family

Table 1. Presentations of Sexual Abuse

Presumptive
Complaint of sexual abuse
Sexually transmitted disease in young child
Unexplained genital trauma
History of sexually abused parent

Possible
Recurrent vaginitis
Precocious sexual interest
Excessive parental concern for child's genitals
Pregnancy in *young* adolescent

Nonspecific
Behavior disturbances
Complaint of unexplained genital pain
Adolescent runaway
Secondary enuresis
Adolescent prostitution

which would benefit only from a complex, longer-term, and multimodal family psychotherapy. Such family therapy almost always depends on the court, both for initiation and for continuation. The physician can, however, help the process by remaining supportive and continuing to give medical care.

6. Active participation within the community to assure that sexually abused children receive competent medical, legal, and psychological care.

Evaluation

The evaluation begins with identification. Sexually abused children present in a variety of ways, the simplest presentation being an actual complaint of sexual abuse. Every allegation, no matter how incredible, must be considered and viewed as a legitimate sign of distress. Venereal disease, particularly gonorrhea, in prepubertal children must be meticulously investigated to identify the source and mode of transmission. Although ophthalmic gonorrhea can be transmitted by finger-eye contact, it is becoming increasingly clear that gonococcal vaginitis, urethritis, pharyngitis, and proctitis are sexually transmitted,[8,9] despite claims to the contrary.[10] Unexplained genital trauma or vaginal bleeding should lead one to suspect sexual abuse, just as evidence of unexplained trauma in other areas makes one suspicious of physical abuse.[11]

Behavioral manifestations of sexual abuse present the greatest diagnostic dilemma for the physician. Since younger children tend to act out feelings rather than verbalize the conflict, they may present with a variety of behavioral problems. It is not uncommon to discover[12] that children in treatment for various types of behavior problems have been molested prior to treatment. Obviously, not all behavioral or emotional symptoms are related to sexual abuse. However, when the etiology is unclear, the mother had been sexually abused as a child, the symptoms relate to the genitals, and the family characteristics are indicative of the "character disordered family,"[13] sexual abuse must be considered.

Table 1 lists the common presentations in sexual abuse in the order of decreasing suspicion. It is noteworthy that young prostitutes[14] and runaway adolescents[15] have a higher than expected frequency of having been sexually abused.

Preparation for the Physical Examination

Careful preparation makes the evaluation easier for all concerned and begins with the first contact the child's family has with the medical facility. All professionals must remain calm and in control. The children and families are frightened, angry, and anxious; these feelings must be acknowledged and dealt with. Although there is a tendency to

"get it over with as quickly as possible," particularly when specimens must be collected, the evaluation must proceed slowly and gently.

Extreme pressure from parents to perform a gynecological examination must be carefully analyzed and any hidden agendas explored. Pressure, motivated solely by a desire to obtain information about their adolescent daughter's sexual activity, is usually indicative of family dysfunction; a pelvic examination may not help anyone.

Because the family is involved in all types of child sexual abuse, one must gain their cooperation. If the abuse is extrafamilial they may be angry and revengeful; if it is intrafamilial they will be frightened and defensive. Even sexually abusive parents can be helped to cooperate with the physician in the initial evaluation. Continued cooperation, in these cases, must be assured by police and court involvement.

The child and accompanying adults must be escorted to a private area and not be required to give details in a public place. Priority is just below life threatening emergencies. The victim remains fully clothed and supportive adults should remain for most of the evaluation.

Although history taking has been described elsewhere,[16] a knowledge of the child's development is essential. The examiner must gauge the cognitive and developmental level of the child and use words and phrases which are indicated for that particular child. After acknowledging the obvious reasons for the visit and a brief explanation that "we will talk for a while," engaging the child about less threatening topics is helpful. If the physician can get the child to talk about subjects that lower the level of anxiety, the chances of getting cooperation with the history and physical examination are much better. A thorough history is necessary because it determines, to a large extent, the course and extent of the physical examination.

The Examination

The examination should begin as a general physical examination, and in all cases include an inspection of the external genitalia. Any abnormalities, particularly skin marks which could be indicative of trauma, should be carefully noted as to size, color, and location. An estimation of the age may be added. Drawings or photographs are particularly helpful, because physical and sexual abuse can occur concomitantly.

Particular attention should be paid to the anal region looking for abrasions, erythema, semen (semen fluoresces dark green under Wood's light examination), or fissures. Anal penetration is likely to have been traumatic.[7] Anoscopy is indicated if anal trauma is present.

The examination of external genitals in males should include gentle pressure on the penile urethra. Pain or discharge indicates urethritis. Urethritis is extremely rare in prepubertal and non-sexually active males, and if present indicates urethral instrumentation or sexual intercourse. Any urethral discharge must be Gram stained and cultured for Neisseria gonorrhea.

The vulva can be easily inspected after one has gained the girl's cooperation. This will be facilitated by explaining the procedure carefully, allowing the child to have some control over the pace of the procedure and, frequently, having the help of the "trusted person" who accompanied the girl. Stirrups should not be used as young girls are frightened by them. Visualization will be ideal if the girl will clasp her abducted knees while lying on her back. This position also allows her a degree of control. The anatomy of the prepubertal girl allows adequate visualization of the distal one third of the vagina, if gentle downward and lateral pressure is exerted posterior and lateral to the forchette. The "trusted adult" can help in these maneuvers. Sedatives and analgesics are not usually helpful.

Findings are to be described in detail. Diagrams are very helpful in showing the location of abnormalities. The hymenal opening and size should be estimated.[17] The term "intact" is confusing and not helpful. There is frequently pressure from relatives, police, the district attorney, social workers, defense lawyers, and others to classify the hymen as "intact" or "virgin." Since the crime of sexual abuse is not dependent solely on the state of the hymen and "intact" hymens may not be "virginal," these terms are not helpful. Statements about signs of recent trauma or their absence and size of hymenal opening are helpful. Documentation must be explicit.

When the pressure for establishment of "virginity" arises from the parents, the physician must carefully determine the underlying reason for the

request. It may be an expression of legitimate concern for the child's well-being—particularly common in cultures where "virginity" is highly valued. It may also be a signal that family dysfunction is present, and the concern is a thinly disguised veil for an intrusion into an adolescent's sexuality. Exploration with the parents will usually clarify the reason for the request.

If there is no evidence of trauma and the hymen is present and not traumatized, a speculum examination is not indicated since specimens may be obtained carefully through the hymenal opening, using a sterile eyedropper or cotton-tipped applicator moistened with saline. The aspirated contents can be Gram stained and cultured for N gonorrhea and examined for sperm, acid phosphatase, and ABO blood typing of the sperm if the history suggests penetration. Semen is almost never identified after more than 72 hours following coitus,[18] thus collecting these evidenciary specimens in these circumstances is not indicated.

The child with genital trauma, lacerated hymen, or vaginal bleeding must have a careful inspection of the entire vaginal vault and pericervical area regardless of how small the bleeding may be. Traumatic insertion of foreign objects can cause serious and lethal vaginal lacerations which require immediate surgical intervention, even though there is little external evidence of trauma beyond the vaginal bleeding.[19]

All children with unexplained vaginal bleeding must have a thorough inspection of the entire vagina and cervix, under general anesthesia if necessary. It is a common mistake to allow the concern about the small hazards of general anesthesia to outweigh the larger risks of missing a serious vaginal laceration. The non-gynecologist is advised to call for expert gynecological assistance at this point.

Speculum examination, however, presents a problem for all but the older latency-age and adolescent girls. Even the gentlest examination is likely to be difficult for the frightened girl who has been sexually abused. The author has not found pediatric specula helpful, even with the concomitant use of analgesics and tranquilizers. These specula are frequently too short to allow adequate visualization and may tear or stretch the hymen, causing additional pain. Examination under general anesthesia is indicated when difficulty is encountered.

In the older children, who can cooperate, visualization of the vaginal vault is accomplished with pediatric vaginascope or a pediatric anoscope. An inexpensive substitution is a plastic veterinary ear speculum. This is useful in younger children, prior to the onset of puberty. Its length is adequate and the diameter is sufficiently small; however, visualization of the posterior vaginal vault may be difficult.

Collection of Evidence

All states require reporting of sexual abuse of children. However, permission from parents or others who are responsible for temporary custody (police) is required to collect evidence. Some states allow children 12 years of age and older to consent to the examination and the collection of evidence. The chain of custody must be preserved if the results are to be admissible as evidence in court; each individual who takes possession of the specimens must document that he has done so. After consent has been obtained and if the alleged event had occurred less than 72 hours prior to the examination, evidence for specimens should be collected according to the instruction (Table 2), modified from Pascoe.[11] All vaginal specimens may be obtained atraumatically through the hymenal ring. Sites for obtaining cultures include the vagina, anus, oropharynx, and the male urethra if urethritis is present. All sites should be cultured if there is a history of loss of consciousness, drug usage, or vague history, especially in a young child. Cultures are usually not performed by police laboratories and must be processed separately.

Laboratory Tests

Laboratory tests are a mandatory part of the evaluation. When non-ophthalmic gonorrhea is diagnosed in the prepubertal child, this may be the only evidence available to indicate possible sexual abuse.[8] Consequently, all specimens must be handled carefully. They are to be innoculated immediately onto Thayer-Martin or transport

**Table 2. Procedure for Collecting Specimens in Cases of Child Sexual Abuse*
—LABEL ALL SPECIMENS—**

Clothing
Collect all clothing, debris, hair, leaves, and other materials. Place in a bag and seal.

Fingernail Scrapings (if patient fought)
Scrape beneath the nails or clip; place in a test tube.

Pubic or Other Hair
If suspected, retrieve foreign hairs, place in an envelope, and indicate source. Normal pubic or scalp hair may be plucked at this time and sent as a comparison.

Wood's Lamp
Semen fluoresces dark green under Wood's lamp. Collect specimens from any suspicious areas.

Sperm Identification
Collect material from the vaginal vault or the posterior fornix, using a cotton swab or glass dropper. Place a drop on a slide and examine under high, dry power for motile sperm. Record finding in the chart as presence or absence of sperm and their motility.

Swab all suspicious areas (mouth, anus, labia, vagina, cervix) with separate applicators. Swab onto two slides and air-dry. Preserve a swab in 1 cc normal saline.

Acid Phosphatase
With cotton swabs, collect specimens from any suspicious areas. Air-dry, place in tubes, and cover. Place an additional swab in buffered albumen.

ABO Blood Semen Typing
With a cotton applicator, swab suspicious areas. Best specimens of semen traces are areas that are not contaminated by the patient's own secretions (behind molars and under tongue).

*Adapted with permission from Pascoe DJ: Management of sexually abused children. *Pediatric Annals* 8:309, May 1979
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medium and properly incubated. The laboratory must be able to identify the species of Neisseria by sugar fermentation.

All children should have a serological test for syphilis. If they are not treated prophylactically with procaine penicillin, the serology must be repeated in two months. Evidence of ejaculation should be sought, if the clinical situation suggests it. Semen can be detected by its dark-green fluorescence under Wood's light; acid phosphatase is measured by the laboratory, and ABO blood typing of the semen from the vagina, rectum, and mouth (under the tongue and behind the molars), are all necessary.

Treatment

All trauma should be handled according to standard medical procedures. If a vaginal discharge is present, it should be cultured for routine pathogens and on Thayer-Martin medium for Neisseria gonorrhea. In prepubertal females and in males, a Gram stain which reveals gram-negative intracellular diplococci is presumptive evidence for gonorrhea infection,[20,21] and calls for treatment. It must be confirmed by culture but treatment may be initiated pending culture results. Candida vaginitis is not necessarily sexually transmitted, and is occasionally diagnosed even in prepubertal girls. While Trichomonas vaginalis is sexually transmitted, T hominis may be a normal colon inhabitant. Careful laboratory examination can discriminate these organisms. Miconazole nitrate 2% vaginal cream is easier to use (tuberculin syringe for application) than a suppository for candidiasis. Metronidazole (Flagyl) remains the recommended treatment for trichomoniasis, at the dose of 10 mg/kg/day for seven days (maximum dosage 250 mg three times a day).

Venereal Disease Prophylaxis

Venereal disease prophylaxis[22] is recommended whenever there is evidence of genital trauma and history that is suggestive of penile penetration. Ampicillin 50 mg/kg to a maximum of 3.5 gm as a single oral dose, preceded by probenicid (25 mg/kg to a maximum of 1 gm) is an effective prophylactic regimen to prevent gonorrhea. Its effect (and those of all other non-procaine penicillin treatments) on incubating syphilis is unclear and a serology must be repeated in two months. Procaine penicillin 100,000 units/kg in two intramuscular doses (for a maximum of 4.8 million units), combined with oral probenecid is an equally effective treatment. A child *over* eight years old who is allergic to penicillin may be treated either with intramuscular spectinomycin dihydrochloride pentahydrate (Trobicin) in two divided doses, 40 mg/kg (2 gm maximum), or oral tetracycline 25 mg/kg (1.5 gm maximum) in a single dose followed by 10 mg/kg (2 gm maximum) four times a day for four days. Erythromycin, 40 mg/kg (2.0 gm maximum) for ten days remains the treatment of choice in the penicillin allergic child under eight years of age.

Pregnancy Prophylaxis

All pubertal adolescents who show evidence of vaginal penetration, particularly that which occurs at mid-cycle and who do not use regular contraceptive methods, must be offered the alternative of postcoital prevention of pregnancy. After bimanual vaginal-abdominal examination has demonstrated the absence of pelvic pathology and a serologic radioimmunoassay (RIA) for human chorionic gonadotropin (HCG) is negative, prophylaxis *may* be indicated:

1. Five days of diethystilbestrol (DES) (25 mg twice a day) or ethinyl estradiol (2.5 mg twice a day) given within 72 hours after coitus is 90 to 95 percent effective in preventing pregnancy.[23] These cause severe nausea and thus a concomitant antiemetic must be given. Since DES has been strongly implicated in fetal genitourinary abnormalities and vaginal malignancies,[24] should pregnancy occur, a therapeutic abortion must be strongly recommended. The adolescent girl and her parents must be aware of this prior to using DES.
2. A Copper 7 intrauterine device inserted post coitus[25] is not suitable for most adolescents because of multiple complications, including that of increased risk of pelvic inflammatory disease.
3. As an increasingly acceptable alternative, once it has been determined that the victim was not pregnant prior to the assault, the following is suggested: the victim may elect to wait seven to ten days when a serum determination for HCG may be obtained. If it is negative, it is highly unlikely that conception has occurred. If it is positive, a menstrual extraction can be performed. This is a safe, rapid procedure. Waiting for the next menstrual period after sexual assault is a highly anxious situation for girls and is no longer necessary.

The Post Evaluation Conference

At the conclusion of the evaluation the physician should discuss the findings with the victim and the supportive adult. The medical report frequently amounts to reassurance that the child has not been physically damaged. Older children are encouraged to confirm this by self-examination.

Injuries or abnormal findings are carefully explained. Venereal disease and pregnancy prophylaxis, where appropriate, must be discussed. Guidance should be given to the parents and older children about the expected appearance of certain common reactions to the discovery of sexual abuse—anxiety (generalized and/or manifested by phobias), somatization, regressive behavior including difficulty in separating from parents, enuresis, and sleeping or eating disturbances. In order to help facilitate working through the event, the parents should be encouraged to talk about the problem at the child's pace.

A frank but sensitive discussion with the parents or adults responsible for the girls who have experienced vaginal penetration is indicated. It should briefly explore the reactions to the event: anger, guilt, shame, and ways in which they believe the "rape" may change their view of their daughter, eg, she is no longer a virgin.

At this time the legal implications of the alleged sexual abuse should be discussed. Reporting procedure, police involvement, and protective custody of the child are presented to the parent(s) and the victim. The police or caseworkers who accompany the child must receive a copy of the medical evaluation, any specimens collected, and a careful explanation and interpretation of the findings because all too frequently police and caseworkers lack sufficient knowledge about sexual abuse to interpret the findings.

All children should be seen within a week to assure the proper treatment of any reported abnormalities detected at the initial evaluation, and to see that the proper legal and therapeutic modalities have been employed. Children should be seen two months after this initial evaluation for a repeat syphilis test if they have not received prophylactic treatment against syphilis. It is the author's belief that all victims of incest and those who demonstrate persistent difficulty in coping with the abusing incident should be referred for psychotherapy.

Summary

The evaluation of sexually abused children is always disturbing. Physicians, nurses, parents, and the victim are distressed and frightened. However, if the physician is conscious of his role, knowledgeable about the problem of sexual abuse, and confident about the necessity for such an evaluation, the best interests of the child victim are likely to be served.

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