

# A Case of Herpes Genitalis Associated with Childhood Sexual Abuse

Koo Il Seo, M.D., Kyu Han Kim, M.D., Jee Ho Choi\*, M.D.

*Department of Dermatology, Seoul National University College of Medicine,  
Seoul, Korea*

*Department of Dermatology, Asan Medical Center\*, University of Ulsan,  
Ulsan, Korea*

**We report a case of recurrent herpes genitalis in a 5-year-old girl which was considered to result from childhood sexual abuse. The skin lesion was an eroded erythematous macule with overlying multiple vesicles on the labia majora. We detected Herpes simplex virus DNA by using the polymerase chain reaction (PCR) in a biopsy specimen from the vesicular lesion.**

**(Ann Dermatol 5:(1) 41-43, 1993)**

*Key Words:* Childhood sexual abuse, Herpes genitalis, Herpes simplex virus, PCR

Child abuse has already attracted great concern, not only as a medical problem, but also as a serious social problem in the western part of the world. Especially childhood sexual abuse is regarded as 'the last frontier of child abuse'.

We herein report a case of a 5-year-old girl with recurrent herpes genitalis which was considered to result from childhood sexual abuse.

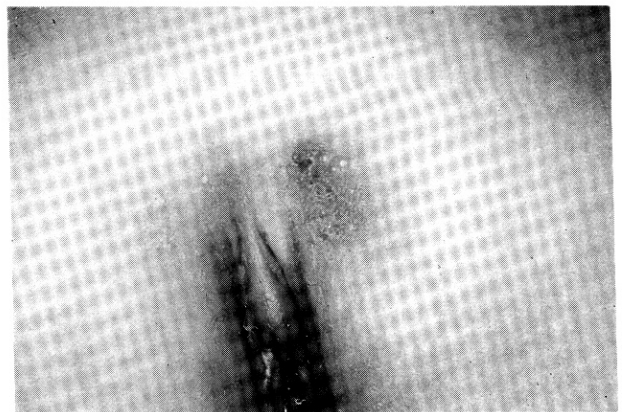
## REPORT OF A CASE

A 5-year-old girl had 3 episodes of erosive vulvar lesions. The first episode developed 3 months prior to being seen, and the skin lesions resolved in about 2 weeks. On her first visit, erythematous, slightly macerated and eroded macules with overlying grouped vesicles were observed on both upper sides of the labia majora (Fig. 1).

Under the impression of herpes genitalis, we asked her mother and herself about the possibility of childhood sexual abuse and we elicited a definite sexual abuse history perpetrated by a male cohabitant. Her mother was a widow and the

girl told her mother that the male cohabitant frequently and forcibly fondled her genital area with his hands when her mother was out for work. However, the history of genital to genital contact could not be detected because of her young age.

A biopsy specimen taken 1 month later when new vesicles developed showed numerous multinucleated giant cells and inclusion bodies within the vesicle. These findings were compatible with herpes virus infection (Fig. 2). In addition, the polymerase chain reaction (PCR) was used to confirm the presence of Herpes simplex virus (HSV)

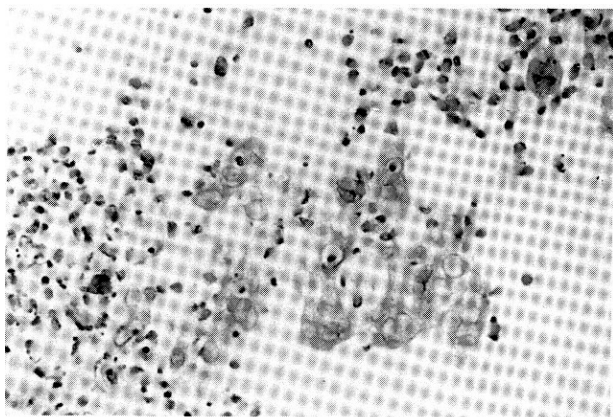


**Fig. 1.** Erythematous, slightly macerated macules with erosion and vesicles on labia majora.

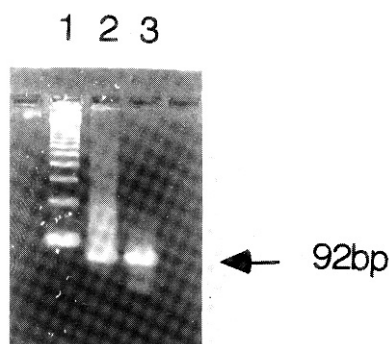
Received June 3, 1992

Accepted for publication July 20, 1992

**Reprint request to:** Koo Il Seo, M.D., Department of Dermatology, Seoul National University, College of Medicine, Seoul, Korea.



**Fig. 2.** Biopsy specimen taken from the vesicular lesion showed numerous multinucleated giant cells and inclusion bodies (H & E stain,  $\times 400$ ).



**Fig. 3.** PCR using the biopsy specimen showed 92bp amplified product (Herpes Simplex Virus). (Arrow)

1. 123-bp DNA ladder (DNA size standards)
2. Our case
3. Positive HSV DNA band at 92bp (herpes simplex patient)

DNA. We used a pair of 22 bases oligonucleotide, sense primer 5'-CATCACCGACCCGGAGAGGGAC-3' and antisense primer 5'-GGGCCAGGCGCTTGTTGGTGTA-3', which identifies the common DNA base pairs of HSV-1 and HSV-2. These two primers were proved to be specific for DNA of HSV by Cao *et al.*<sup>2</sup>. In this case, HSV DNA was detected in paraffin-embedded tissue, which gave a 92bp amplified product (Fig. 3). VDRL and TPHA were performed to detect the presence of superimposed syphilis, of which the result was non-reactive.

The patient was treated with acyclovir 600mg per day for 7 days for reduction of the duration and the severity of the herpes genitalis and erythromycin syrup and Fucidin® ointment for the

prevention of secondary infection. The skin lesion was nearly healed on the next visit, 2 weeks later. The mother of the patient was also advised to separate the patient from the perpetrator so as to prevent further sexual abuse.

## DISCUSSION

Herpes genitalis is caused by HSV (chiefly type II and occasionally type I) and occurs mostly following sexual exposure to a sexual partner with active lesions. Person to person contact is the mode of transmission of herpes genitalis for the majority of the patients but nonvenereal transmission of genital herpes has not been well studied or documented<sup>3</sup>. With the aid of the definite sexual abuse history, histopathologic findings and PCR technique, we concluded that this case must have been herpes genitalis resulting from childhood sexual abuse. Subtype of HSV was not determined because the vesicle fluid for culture was not available.

Childhood sexual abuse (CSA) has emerged from obscurity to a point at which few branches of medicine have remained uninvolved. Dermatology is no exception. Many dermatologists will be confronted with cases in which the possibility of CSA is high.

What are the possible signs or symptoms in the dermatologic field for suspicion of CSA? The commonest sign is reddening of the vulva. Other signs include vulval abrasion, edema, pouting of the urethra, tenderness, vaginal discharge, scars of the posterior fourchette, dilatation of the hymenal opening, tears in the hymen, reflex anal dilatation, reddened anus, venous engorgement around the anus, increased vaginal introital diameter and labial adhesion<sup>4,7</sup>. In our case, reddening of the vulva and vulvar abrasion associated with herpes simplex infection were detected.

In addition, sexually transmitted diseases (STD) such as condyloma acuminatum, gonorrhea, syphilis, herpes genitalis, chlamydial infection, trichomonas vaginalis, AIDS and molluscum contagiosum confined to the genital area, should not be missed because STD is a well-recognized complication of CSA<sup>8</sup>. In this case, we could not find any other signs to suspect STD except vulvar abra-

sion, so we performed only the serologic test for syphilis. Children known or strongly suspected to be victims of CSA should be investigated to exclude STD. That is, it is important to suspect the possibility of CSA when confronted with childhood patients with genital symptoms or STD.

The first step when a dermatologist suspects CSA is to discuss the matter with the most experienced colleagues available—usually pediatricians and child psychiatrists. It is, however, important to minimize the frequency of examination of the victims because intervention by professionals may sometimes be perceived by the child as worse than abuse. The second step is to investigate the possibility of STD and other organic medical problems and immediately initiate the proper treatment. If it is felt necessary to remove a child from the home environment during an investigation, admission of the child to hospital usually achieves this aim. Finally, discussion of the matter with other social workers of the hospital or government, and reporting to the authorities concerned, if necessary, should be done<sup>9</sup>.

The things about CSA in the Orient, including Korea, are not thought to be much different from the western part of the world. There are no case reports or epidemiologic studies on CSA in Korea. The traditional ideas of Confucianism has made

CSA underestimated, obscure, and even covered up secretly. Great concern should be given to CSA and dermatologists should be aware of the existence of CSA.

## REFERENCES

1. Sgroi SM: *Sexual molestation of children: the last frontier in child abuse*. *Child Today* 4:18-21, 1975.
2. Cao M, Xiao Z, Egbert B, et al: *Rapid detection of cutaneous Herpes simplex virus infection with the polymerase chain reaction*. *J Exp Med* 82:391-392, 1989.
3. Neinstein LS, Goldenring J, Carpenter S: *Nonsexual transmission of sexually transmitted diseases: an infrequent occurrence*. *Pediatrics* 74:67-76, 1984.
4. Hobbs CJ, Wynne JM: *Child sexual abuse—an increasing rate of diagnosis*. *Lancet* i:837-841, 1987.
5. Emans SJ, Woods ER, Flagg NT et al: *Genital findings in sexually abused, symptomatic and asymptomatic girls*. *Pediatrics* 79:778-785, 1987.
6. Hobbs CJ, Wynne JM: *Buggery in childhood—a common syndrome of child abuse*. *Lancet* ii:792-796, 1989.
7. White ST, Ingram DL: *Vaginal introital diameter in the evaluation of sexual abuse*. *Child Abuse and Neglect* 13:217-224, 1989.
8. White ST, Loda FA, Ingram DL et al: *Sexually transmitted diseases in sexually abused children*. *Pediatrics* 72:16-21, 1983.
9. Berth-Jones J, Graham-Brown RAC: *Childhood sexual abuse—a dermatological perspective*. *Clin Exp Dermatol* 15:321-330, 1989.