

CASE REPORT

A Diagnostic Challenge: Multidisciplinary Management of Non-Consensual Sodomy in an Adolescent Male

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ABSTRACT

Non-consensual sodomy in adolescents often presents with atypical symptoms, posing diagnostic and management challenges for healthcare providers. This case report describes a 17-year-old male who presented with acute epigastric pain, vomiting, and psychological distress, later disclosing a traumatic sexual assault by multiple perpetrators. Physical examination revealed an anal fissure and chest ecchymoses, consistent with the reported assault, and an examination under anaesthesia (EUA) confirmed the extent of the injury. Management was guided by a trauma-informed approach, emphasizing safety, trust, and empowerment to minimize retraumatization. A multidisciplinary team provided comprehensive care, including surgical intervention, psychiatric support to address psychological distress and self-harm behaviour, and social services to ensure safety and legal assistance. This case highlights the importance of physician vigilance in recognizing atypical presentations of sexual violence and the critical role of integrated care approaches rooted in trauma-informed principles. Addressing the physical, psychological, and social dimensions of trauma is essential to improving outcomes for adolescent survivors.

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INTRODUCTION

Sexual violence remains a pervasive global public health issue, disproportionately affecting vulnerable populations such as adolescents. The World Health Organization (WHO) highlights the profound and lasting physical, psychological, and social consequences of sexual violence, often exacerbated by stigma, underreporting, and delayed access to care (1). Sexual assault involving anal penetration, as an extreme form of sexual violence, is particularly challenging to address due to its frequent

presentation with non-specific or atypical symptoms, complicating timely recognition and intervention. Adolescents face unique barriers to disclosing sexual violence, including fear of stigma, shame, mistrust of authority figures, and limited understanding of their rights. These challenges necessitate the adoption of a trauma-informed approach, which prioritises safety, trust, and empowerment while addressing the survivor's physical and emotional needs. Trauma-informed care fosters a non-judgmental, empathetic environment that encourages disclosure and minimises retraumatization during clinical interactions.

In clinical practice, atypical presentations of sexual violence, such as gastrointestinal complaints, often obscure the underlying cause, delaying diagnosis and

treatment (2). Recognising psychological cues, such as anxiety, withdrawal, or unexplained distress, is essential for identifying underlying trauma. A trauma-informed framework ensures that healthcare providers approach such cases with sensitivity, focusing on both immediate physical needs and the broader psychological and social implications.

This report examines an adolescent male who presented with acute epigastric pain and psychological distress, later disclosing a history of sexual assault involving anal penetration. By exploring this case, the report advocates for a trauma-informed and multidisciplinary approach, emphasising the importance of physician vigilance, integrated care, and survivor-centred practices. This case highlights the critical need for healthcare systems to address the physical and emotional repercussions of sexual violence comprehensively, particularly in adolescents, a population often underserved in clinical settings.

CASE PRESENTATION

A 17-year-old male presented to the emergency department (ED) with sudden-onset epigastric pain, described as a burning sensation radiating upwards and aggravated by spicy food consumption. He also reported loose stools and five episodes of non-bilious, non-bloody vomiting over the past 24 hours. During the clinical interview, he expressed concern about HIV symptoms, prompting a sensitive exploration of recent risk exposures. He later revealed that he may have been sexually assaulted by around ten individuals two days earlier.

According to the patient, acquaintances lured him to an unfamiliar location under the pretext of a social gathering. He was offered a carbonated beverage, after which he lost consciousness. Upon regaining awareness, he experienced intense abdominal and anal pain, emotional confusion, and observed multiple bruises on his chest. He recalled being subjected to non-consensual anal penetration by multiple individuals. The patient consistently denied having consented to any form of sexual activity and expressed profound psychological distress, including feelings of shame and helplessness. There was no indication that he had knowingly entered a high-risk environment or anticipated any form of sexual encounter. On the following day, the patient attempted self-harm with a sharp object, causing a superficial laceration on his left forearm; however, he did not seek medical attention.

The patient was calm and cooperative on examination but exhibited a low mood and flat affect. His vital signs were stable. Abdominal palpation revealed tenderness in the epigastric region without guarding or rebound. Multiple ecchymoses, measuring approximately 2 × 2 cm each, were observed on the anterior chest wall

and were consistent with bite marks. A superficial linear laceration (5 × 0.5 cm) was present on the left forearm. Perianal examination revealed a fissure at the 5 o'clock position, measuring 2 × 2 cm, with surrounding erythema and tenderness. Laboratory investigations showed an elevated white blood cell count, while other parameters were within normal limits. Examination under anaesthesia (EUA) confirmed the presence of the anal fissure without evidence of deeper mucosal or rectal injury. Given the circumstances of drug-facilitated sexual assault, coercion, and the involvement of multiple perpetrators, the incident was managed clinically and legally as a case of sexual assault involving anal penetration.

A psychiatric assessment was conducted to evaluate his mental state and cognitive capacity. The patient was alert, fully oriented, and able to provide a coherent and consistent narrative of the incident. There was no evidence of intellectual disability, developmental delay, or psychotic features. However, he exhibited symptoms of acute psychological distress, including persistent low mood, emotional detachment, intrusive recollections, and self-harming behaviour. These features were consistent with an acute stress reaction. While his symptoms raised concerns for potential post-traumatic stress disorder (PTSD) or a mood disorder, a formal diagnosis was deferred due to the recency of the event. He was considered at high risk for developing trauma-related psychopathology and was referred for ongoing psychiatric support. Although self-injurious behaviour may raise concern for underlying personality pathology, the patient did not exhibit other features suggestive of borderline personality disorder (BPD), such as identity disturbance, impulsivity, or unstable interpersonal relationships.

The patient did not disclose his sexual orientation, nor did he report any history of romantic or sexual relationships. He expressed no concerns regarding gender identity, and no clinical signs were observed to suggest gender dysphoria or gender non-conformity. At no point did he describe having a girlfriend or engaging in consensual sexual activity. Given the nature of the incident the encounter was classified as a case of sexual assault and sodomy, in accordance with medico-legal and ethical standards. Further exploration into sexual orientation or past sexual history was not pursued during initial evaluation, in keeping with trauma-informed care principles.

Initial management included intravenous Tramadol for pain control and intravenous Pantoprazole for gastric protection. The surgical team provided assessment and wound care for the anal injury. The psychiatric team initiated crisis intervention, addressing emotional containment, suicide risk, and safety planning. Social services were engaged to ensure the patient's immediate protection, facilitate legal reporting, and coordinate with

child welfare and law enforcement authorities. All care was delivered within a trauma-informed framework, prioritising trust, empowerment, and minimising the risk of re-traumatisation.

During follow-up, the patient demonstrated gradual psychological improvement, including reduced emotional distress, better affect regulation, and increased engagement in therapy. He remained under multidisciplinary care, which included regular psychiatric monitoring, individual counselling, and coordinated social service support. As part of his psychological rehabilitation, he underwent Trauma-Informed Cognitive Behavioural Therapy (TI-CBT). Continued intervention focused on fostering emotional recovery, strengthening adaptive coping strategies, and ensuring safe reintegration into a stable and supportive environment.

DISCUSSION

This case highlights the critical need for clinical vigilance in recognising atypical presentations of sexual violence in adolescents. The patient initially presented with gastrointestinal symptoms suggestive of a benign physical condition. However, sensitive and thorough evaluation revealed a recent history of drug-facilitated sexual assault involving anal penetration. This diagnostic trajectory illustrates how survivors of sexual violence often present with somatic complaints that may mask underlying trauma. In adolescents, such presentations are not uncommon and may reflect a complex interplay of physical injury and psychological distress (1,2).

Management of this case highlights the essential role of a multidisciplinary team in supporting adolescent survivors of sexual assault. The emergency team was key in stabilising the patient, recognising psychological red flags, and initiating appropriate referrals. The surgical team managed the anal injury and conducted an EUA, which not only confirmed the extent of injury but also provided crucial forensic documentation for legal purposes (3). The psychiatric team addressed acute psychological distress and self-harming behaviour, ensuring emotional safety and early intervention (2). Social services ensured protection, supported legal reporting, and linked the patient and family to community resources, helping to coordinate care across medical, legal, and social systems. This trauma-informed, team-based approach ensured that the patient's physical, emotional, and social needs were addressed together—principles of safety, respect, and patient autonomy guided care. Throughout, providers remained sensitive to his psychological state, helping to reduce re-traumatisation and support his sense of control and dignity (4).

From an educational perspective, this case underscores the need for enhanced provider training in adolescent

sexual violence. Adolescents may delay disclosure due to shame, fear of judgment, or lack of understanding about their rights. These barriers often lead to underreporting and missed opportunities for intervention. Incorporating trauma-informed communication strategies into clinical education can empower providers to recognise subtle cues, respond with empathy, and create a safe space for disclosure. Standardised protocols that embed multidisciplinary collaboration can further enhance the quality and consistency of care.

Future directions should include the development of age-appropriate, evidence-based guidelines tailored to the unique biopsychosocial profiles of adolescent survivors. Continued research is also needed to explore the spectrum of clinical presentations among this population, especially the somatic manifestations of trauma. Moreover, implementing trauma-informed frameworks at the institutional level can create robust support systems that foster resilience, healing, and a sense of safety for young survivors of sexual violence. Ultimately, this case reinforces the need for clinicians, particularly in emergency and primary care settings, to recognise atypical signs of sexual trauma and respond with a multidisciplinary, survivor-centred approach.

CONCLUSION

This case highlights the complexity of managing sexual violence in adolescents with atypical presentations, emphasising the critical role of physician vigilance and a trauma-informed approach that prioritises safety, trust, and empowerment. Multidisciplinary management addresses care's physical, psychological, and social dimensions, facilitating immediate recovery and laying the foundation for long-term well-being. Key lessons include the need for heightened awareness of atypical presentations, sensitive history-taking, and standardised holistic care protocols. Advancing clinician education, enhancing trauma-informed practices, and fostering research are essential to improving outcomes for survivors and supporting their recovery.

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