Acute Sexual Assault Guidelines: Prepubertal Child (< 72 Hours)

This card outlines the steps a practitioner should follow to care for a prepubertal child after an acute sexual assault. Emergency room triage should first notify the social worker on call. The social worker and the medical provider collaborate to obtain history, assess safety, and make referrals. If additional consultation is needed, page the Child Abuse provider on call.

History

- *Specifics of incident*—Who, what, *time*, *date*, where, type of contact (p/v, p/m, p/a, hand/genital, mouth/vagina, penetration, bite, kiss), pain/bleeding, ejaculation.
- *Medical history*—Allergies, medications, Hep B and Td immunization status, prior sexual abuse.
- *ROS*—Anal, genital, oral: vaginal/anal itching, discharge, bleeding, pain, dysuria, frequency, urgency, constipation/diarrhea, sore throat, nausea, fever, behavior, sleep, school.

Physical

- *Woods lamp*—Nonspecific, but may help guide swabs.
- *Sexual assault evidence collection kit*—Buccal standard plus swabs based on history: oral, GU, vagina, rectal, lick/kiss/bite areas. Speculum exam not indicated. Always collect diaper/underwear and linens in a paper bag, as they provide the best source of evidence in children.
- *Complete PE*—Document injuries: photos (colposcopic and/or digital), note, diagram.

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Lab

Blood

- RPR, HIV, Hep B panel, and add Hep C (if indicated because of high risk).
- If suspected drug or alcohol exposure, perform drug investigation test.
- Date rape drugs (GHB/Rohypnol/Ketamine) if within *24 hours* of assault and if suspected. ***Either*** draw and send to Lab ***or*** give to police for crime lab (two 6 ml purple top tubes). DO NOT DO BOTH. Refrigerate.

Urine

- UA (consider evaluating for sperm, trich, and UTI).
- Urine drug test with confirmation if drug exposure suspected. If possible, store for later testing.
- Date rape drug screen—two 6 ml purple top tubes.
- Urine NAAT GC/CT if abuse may have been chronic *or* if symptoms/discharge present. If NAATs are positive, cultures (gold standard) MUST be obtained before treatment.

STI/Cultures (Not necessary in most cases unless abuse was ongoing. Best if done two weeks after sexual contact.)

If signs or symptoms are present, obtain swabs for:

- Gonorrhea culture of throat, rectum, and vagina (or urethral meatus in boys).
- Chlamydia culture of rectum and vagina (culture urethral meatus in boys only if discharge is present).
- Girls—Vaginal wet mount for trichomonads, clue cells, yeast, WBCs, and sperm; whiff test; vag pH.
- General bacterial culture of discharge or orifice—predominant organism.

Optional

- Herpes culture (if lesions present). Order HSV shell vial with typing.
- Urine culture (if indicated).

Medical Treatment

STI prophylaxis is not recommended by the CDC unless there is a high-risk exposure or the family insists.

For children under 45 kg (< 100 lb)

- Antiemetic: Ondansetron (Zofran) 0.1 mg/kg/dose up to 4 mg PO x 1; or Vistaril or Atarax 0.5–1 mg/kg/dose up to 50 mg PO x 1.
- GC: Ceftriaxone 125 mg IM x 1; or Suprax (Cefixime) 8 mg/kg PO x 1 *plus*
  CT: Azithromycin 20 mg/kg (max 1 g) orally, single dose *plus*
  Trich: Metronidazole 15 mg/kg/day orally TID x 7 days.

For children greater than or equal to 45 kg (100 lb)

- Antiemetic: Ondansetron (Zofran) 0.1 mg/kg/dose up to 4 mg PO x 1.
- GC: Ceftriaxone 250 mg IM x 1 or Cefixime 400 mg PO x 1 *plus*
- CT: Azithromycin 1 g orally single dose or Doxycycline 100 mg PO BID x 7 days *plus*
- Trich: Metronidazole 2 g PO x 1.

Consider

- Consult surgery and OB/GYN if an exam under anesthesia (EUA) is needed (all pre-pubertal children with frank vaginal bleeding) or if there are surgical issues.
- HIV prophylaxis if high risk (PEP)—consult HIV team.
- Hepatitis B immunization—Begin or complete if not previously immunized or if status is unknown.
- DTaP or Td immunization—If not up to date or for high-risk anogenital injuries. Consider tetanus immune globulin in severe injuries.

Follow-up

- If minor anogenital injuries or child cannot be examined, refer to Child Protection Center (CPC). *Always fax records to CPC if child is to go to CPC for follow-up. Give CPC brochure to family.*
- Refer to CPC for medical follow-up in two weeks for STI testing. Repeat blood work as shown on the table on the opposite side of this card.

Referrals

Counseling

Helpful numbers

References

American College of Emergency Physicians Handbook on Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient (1999). www.acep.org.

Center of Disease Control 2010, Sexually Transmitted diseases Treatment Guidelines MMWR 2010 59 (No. RR-12).

Red Book 2009 Report of the Committee on Infectious Diseases.

MMWR Recommendations and Reports, January 21, 2005/ 54(02);1-20.

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Acute Sexual Assault Guidelines: Adolescents (< 72 hours)

(Acute Sexual Assault = Any Sexual Contact within 72 hours)

This card outlines the steps a practitioner should consider when caring for a postpubertal adolescent after an acute sexual assault. Emergency room triage should first notify the social worker on call. The social worker and the medical provider collaborate to obtain history, assess safety, and make referrals. If additional consultation is needed, page the Child Abuse provider on call.

History

- *Specifics of incident*—Who, what, time, date, where, type of contact (for example, p/v, p/m, p/a, hand/genital, mouth/vagina, penetration, bite, kiss), pain/bleeding, ejaculation.
- *Medical history*—Allergies, meds, Hep B and Td immunization status, use of contraception, age of menarche, LMP, relevant sexual history.
- *ROS*—Anal, genital, oral; vaginal/anal itching, discharge, pain; abdominal/pelvic pain, dysuria, frequency, urgency, bleeding, areas of soreness, constipation; sleep.

Physical

- *Woods lamp*—Nonspecific: Use with history to guide swabs.
- *Sexual assault evidence collection kit*—Buccal standard plus other swabs as indicated: oral, external genitalia, vagina/cervix (speculum preferred), rectal, bite/lick/kiss areas; pubic hair; dental floss; fingernail; foreign debris; dried secretions—based on history. Clothing in paper bag.
- *Complete PE*—Document anogenital exam and all injuries by photos (colposcopic and/or digital), note, diagram.

Lab

Blood

- RPR, HIV, Hep B panel, and add Hep C (if indicated because of high risk).
- If suspected drug or alcohol exposure, perform drug investigation test.
- Date rape drugs (GHB/Rohypnol/Ketamine) if within *24 hours* of assault and if suspected. ***Either*** draw and send to Lab ***or*** give to police for crime lab (two 6 ml purple top tubes). DO NOT DO BOTH. Refrigerate.

Urine

- UA (consider evaluating for sperm, trich, and UTI).
- Urine pregnancy. Negative result is needed before prophylaxis for STIs and pregnancy.
- Urine drug test with confirmation if drug exposure suspected. If possible, store for later testing.
- Urine date rape drugs (see above) if date rape suspected within previous *4 days*. Refrigerate (crime lab—two 6 ml purple top tubes, used for urine and/or blood). Collect and send to Lab ***or*** police for crime lab. See above.

STI/Cultures (Not necessary for forensic purposes; consider on an individual basis.)

If discharge is present, then:

- Cultures (gold standard) and/or NAAT testing (urine/swabs) for gonorrhea and chlamydia.
- Girls—Vaginal wet mount for trichomonads, clue cells, yeast, WBCs, and sperm; whiff; pH.

Optional

- Urine culture (if indicated).
- Trich culture vaginal or urethral specimens.
- Herpes culture (if lesions present). Order HSV shell vial with typing.

Medical Treatment

- Antiemetic: Administer early if PEP—Ondansetron (Zofran) 4 mg PO x 1; or Vistaril or Atarax 0.5–1 mg/kg/dose up to 50 mg PO x 1.

STI prophylaxis for gonorrhea, chlamydia, trichomonas, and BV

- GC: Ceftriaxone 250 mg IM x 1 or Cefixime 400 mg PO x 1 *plus*
  CT: Azithromycin 1 g PO x 1 dose or Doxycycline 100 mg PO BID x 7 days *plus*
  Trich: Metronidazole 2 g PO x 1 dose.
- BV: Metronidazole 500 mg PO BID x 7 day

Pregnancy prophylaxis

- Give with written informed consent within 72 hours of incident if urine or serum pregnancy is negative. (May administer up to 5 days post event.)
- Plan B: 1.5 mg Levonorgestrel given in one dose.

Consider

- Consult surgery and OB/GYN for serious injuries.
- HIV prophylaxis if high risk (PEP)—consult HIV specialist if needed.
- Hepatitis B vaccine if not previously immunized or status unknown; HBIG if indicated.
- Td immunization when anogenital injuries are present or if not UTD. Consider tetanus immune globulin in severe injuries.
- Herpes Simplex symptomatic treatment: Acyclovir 400 mg PO 3 times/day for 7–10 days or
  Valacyclovir 1 G PO BID for 7–10 days.

Follow-up

- If minor anogenital injuries or exam cannot be done, refer to Child Protection Center (CPC). *Always fax records to CPC if child is to go to CPC for follow-up. Give CPC brochure to family.*
- Medical follow-up in two weeks (PMD, CPC, DHC, or adolescent clinic) for pregnancy, STIs, and other issues. Repeat blood work as shown below.

Time Post Assault to Check Serology

	1 month	3 months	6 months
HIV	×	×	×
RPR	×	×	×
Hepatitis B	×	×	×
Hepatitis C		×	×

Referrals

Counseling

Helpful numbers