

CHAMP Program Child and Adolescent Sexual Offence Post-Assault Testing and Treatment Guide

Every child and adolescent suspected of sexual assault or abuse should have a complete physical examination. Even when there is minimal external physical injury, an examination is important for reassurance of the patient's physical well-being. This in turn can positively influence emotional well-being. The health care provider should determine whether the child or adolescent needs to have an immediate examination in an Emergency Department or be referred to a Child Advocacy Center or other freestanding center. The elapsed time since the incident of abuse, the presence of symptoms, severity of injuries, nature of the abuse, risk of pregnancy, and local availability of providers and resources are key factors in this decision. Whether the sexual assault was a one-time incident perpetrated by a stranger or a family friend, or the result of ongoing familial abuse may also affect treatment decisions.

A mental health assessment and referral for treatment and support can be provided any time after the assault. A listing of crisis intervention programs by zip code is available through the NYS Coalition Against Sexual Assault, www.nyscasa.org.

This guide provides information that applies to both male and female children and adolescents.

The following explanation and accompanying chart will assist in examination decisions. These guidelines do not take the place of consulting an expert.

1. Acute and Follow-up Appointments

Children and adolescents may present emergently, within weeks, or even years post-abuse. An examination to support emotional and physical well-being may be performed at any time after suspected abuse. After abuse, an exam should be performed as soon as possible within the recommended 72 hours, whether or not forensic evidence is collected. Visible physical findings are more likely to be seen when the exam is performed close to the time of the sexual contact. Even if it is beyond the time frame in which forensic evidence may be expected (24 – 96 hours), redness, bruising, or other findings of trauma may be seen. Information regarding triage of sexual abuse may be found at <http://childabusemd.com/triage/triage-overview.shtml>.

After the initial post-assault evaluation, post-assault follow-up examinations may be necessary. Some experts schedule an examination within one to two weeks after the acute examination, particularly if there is poor cooperation for the initial exam, psycho-social concerns, or other unmet needs, or if there is a concern regarding the interpretation of findings. Follow-up appointments are recommended at 6 weeks and 3 months (see Table) in order to provide an opportunity to 1) detect new infections

acquired during or after the assault; 2) reassess regarding pregnancy risk and needs for prevention; 3) reassure regarding healing post-assault; 4) complete hepatitis B and HPV vaccination, if indicated; 5) complete counseling and testing for STIs, including syphilis, HIV, and HBV; 6) assessment for new genital warts (HPV infection); and 7) monitor side effects and adherence to post-exposure prophylactic medication, if prescribed.

2. Forensic Specimen Collection

Based on evidence in adult sexual assault survivors, the New York State Department of Health recommends the collection of forensic evidence within 96 hours of a sexual assault. In prepubertal children, it is rare to find forensic evidence from the child's body beyond 24 hours. The American Academy of Pediatrics guidelines recommend evidence collection for children and adolescents within 72 hours. Newer methods of forensic testing using DNA may extend the time frame for which evidence may be detected, and future research is needed. In all children and adolescents, weigh the benefit of collecting specimens based on the likelihood of a positive finding against the possible discomfort of the patient. Factors affecting the likelihood of identifying forensic evidence include time since the incident, bathing history, age, and type of contact. There have been rare instances of identification of evidence well beyond 24 hours despite the lack of factors, including the lack of disclosure. Decisions for evidence collection should be on a case-by-case basis.

Collection of clothing and linens for analysis is more likely to result in positive findings. In most children, the disclosure of abuse is delayed beyond the window for successful collection of evidence.

3. HIV Testing and Non-occupational Post-Exposure Prophylaxis (nPEP)

Screening for human immunodeficiency virus (HIV) is recommended for all adolescents as part of routine care. When the nature of the sexual assault has been determined to be of risk for HIV transmission, offer HIV testing (despite prior screening) and non-occupational post-exposure prophylaxis (nPEP) against HIV. This should be offered as soon as possible, preferably within one or two hours and up to 36 hours after exposure per NYS guidelines. The interval after which no benefit exists for nPEP is unknown; the CDC recommends treatment within 72 hours. Initiating therapy after a longer interval may be considered for the highest risk exposures. Initiation of nPEP should not be denied if the patient refuses testing.

Risk is determined based on multiple factors, including any known risks of the perpetrator. An algorithm outlining risks for acquisition of HIV, evaluation, and treatment of possible HIV is published by the CDC. See page 107, <http://www.cdc.gov/std/tg2015/tg-2015-print.pdf> (PDF) and see <http://www.hivguidelines.org>.

Consider:

- Potential benefits/risks of nPEP
- HIV status of the assailant
- HIV risk behaviors of the assailant
- Timing of the exposure
- Characteristics of the exposure (Highest risk of transmission from an HIV infected person is associated with anal receptive intercourse.)

Consider consulting a pediatric infectious disease or HIV specialist before prescribing antiretroviral medication. The current preferred regimen for nPEP is a three-drug regimen, with a course of treatment over 28 days. Attempt to obtain assurance that the child or adolescent will return for follow-up. For children and adolescents in foster care, agency approval for testing and treatment is required.

For patients who have ongoing high-risk behaviors, pre-exposure prophylaxis (PrEP) may be offered as part of a comprehensive prevention strategy. This is especially relevant for adolescents involved in domestic minor sex trafficking activities. For more information, see [https://cdn.hivguidelines.org/wp-content/uploads/20160825080651/HIVG AdolescentPrep Meeting-report final 02-18-20161.pdf](https://cdn.hivguidelines.org/wp-content/uploads/20160825080651/HIVG_AdolescentPrep_Meeting-report_final_02-18-20161.pdf).

Follow-up HIV testing should be performed at four to six weeks and at three months. HIV infection is not immediately detectable after initial exposure. The period between the time of HIV infection and the time when tests can detect HIV antibodies varies from person to person and depends on the diagnostic testing method. Nearly all those infected with HIV develop antibodies within three months of infection. Follow-up testing beyond three months is recommended if there is risk of repeat exposures. Anti-retroviral medications for pre and post-exposure should be reviewed at <https://www.hivguidelines.org/pep-for-hiv-prevention/pep-for-children-beyond-the-perinatal-period/> . For further information, check the NYS DOH website www.hivguidelines.org.

4. Pregnancy Prevention and Testing

Adolescent females with a history of exposure to semen are at risk for pregnancy and should be counseled regarding prophylaxis against pregnancy resulting from the sexual assault, also known as emergency contraception. Progesterone-only (such as levonorgestrel) hormonal contraception has been shown to be better tolerated and more effective. Timely action is necessary as prophylaxis is most effective as soon as possible after the incident, optimally within 12 hours. Recommendations are to provide hormonal therapy within 120 hours. Obtain a serum β hCG prior to treatment as well as at one to two weeks after treatment.

5. Sexually Transmitted Infection Testing

Children and adolescents who have been sexually abused may be at risk for developing a sexually transmitted infection, including *N. gonorrhoeae*, *C. Trachomatis*, *T. vaginalis*, herpes simplex virus (HSV), human papillomavirus (HPV), syphilis, HIV, hepatitis B, and hepatitis C. Sites for testing should be based on areas of suspected penetration and findings of lesions (such as with HSV, HPV, or syphilis). However, testing may be warranted for all areas (oral, rectal, and genital) even when the disclosure is unclear or incomplete. Note that STI's, including *T. vaginalis*, may be asymptomatic in prepubertal and adolescent patients. Serum testing for syphilis (RPR), HIV, and hepatitis B are routinely recommended in cases where genital swabs are obtained for other STIs. Hepatitis C may be transmitted sexually. Although not part of the standard recommendation, testing should be considered based on risk factors and exposure.

For adolescents, screening for STI's after an acute incident of assault or abuse is recommended, even when there is a normal examination. The history of acts of abuse and the patient's emotional state should be considered in this decision. If tests are performed for *N. gonorrhoeae*, *C. Trachomatis*, and/or *T. vaginalis*, then serum tests including an HBV panel, HIV, and syphilis testing are also recommended.

For children, decisions to perform tests should be made on an individual basis with each child evaluated for STI risk. Sexually transmitted infections occur infrequently in prepubertal sexually abused children. Risk factors for STIs in prepubertal children include the following:

1. The child has experienced penetration of the genitalia or anus, based on history or physical.
2. The child has been abused by a stranger.
3. The child has been abused by a person known to be infected with an STI or at high risk for an STI.
4. A sibling or other relative in the household has an STI.
5. The prevalence of STIs is high in the community where the child lives.
6. The child has signs of an STI, such as a vaginal discharge.
7. The child has previously been diagnosed with an STI.

Consider a follow-up examination to check for anogenital warts (HPV) at one to two months post-assault for children and adolescents diagnosed with an STI.

Nucleic acid amplification tests (NAATs) are highly sensitive and specific for *N. gonorrhoeae* and *C. trachomatis*, and are more sensitive than a culture. NAATs performed on urine may be used for detecting genito-urinary infection in prepubertal and adolescent girls. Studies to determine the value of the use of NAATs for STI testing suggest that use of these tests may be recommended in the future for testing of the throat and anus in prepubertal children. Current recommendations are for a culture at

these sites. NAATs are sensitive and may result in a positive finding due to perpetrator secretions on the child's body and not necessarily infection.

Tests may include:

- NAAT testing or a traditional culture (see above). Note that for adolescent patients, pharyngeal and rectal swabs may be used if internal validation has been performed by the laboratory. Transcription-mediated amplification (TMA) is recommended over other NAATs. For prepubertal children, a culture should be used for these extra-genital sites.
- Testing vaginal secretions for *Trichomonas vaginalis*, *Candida* species, and bacterial vaginosis. NAATs are recommended for detection of *T. vaginalis* from a urine or vaginal specimen in adolescent patients. For prepubertal children, NAATs are not currently recommended.
- A serum sample for baseline evaluation of HIV, hepatitis B, and syphilis infections.
- A herpes simplex virus (HSV) or human papilloma virus (HPV) test if there are vesicles or condyloma.

Positive results follow-up:

- A positive NAAT result warrants confirmatory testing, especially in areas with low prevalence of disease. Specimens should be held in the lab to allow for this testing.
- Follow-up evaluation should be conducted within one week to ensure that results of positive tests can be discussed promptly and treatment provided if not given at the initial visit.

Negative results follow-up:

- If initial tests were negative and treatment not provided, evaluation for STIs should be repeated within one to two weeks of the assault. This will potentially detect infectious organisms that might not have reached sufficient concentrations to produce positive test results at the time of initial examination.
- If initial test results were negative and infection in the perpetrator cannot be ruled out, serologic tests for syphilis can be repeated at four to six weeks and three months. These tests should also be performed if another test for STIs is positive. See Sexual Assault and STDs, Risk for Acquiring HIV Infection <http://www.cdc.gov/std/tg2015/sexual-assault.htm#riskHIV>.

6. Sexually Transmitted Infections Treatment

Presumptive antimicrobial treatment for STIs such as *N. gonorrhoeae*, *C. Trachomatis*, and *T. vaginalis* in prepubertal children who have been sexually abused is not recommended. However, after testing is performed, providers may consider treatment depending on concerns based on the child's history, parental concerns, or physical findings. Follow-up after sexual assault is often poor, therefore, prophylactic treatment is recommended in high-risk prepubertal children and adolescents. In these cases, empiric antibiotic treatment for chlamydia and gonorrhea is recommended.

For adolescent victims of sexual assault, empiric antimicrobial treatment is recommended for *N. gonorrhoeae*, *C. Trachomatis*, and *T. vaginalis*. For more information and antibiotic dosage, see the CDC website, 2015 Sexually Transmitted Diseases Treatment Guidelines <http://www.cdc.gov/std/tg2015/sexual-assault.htm>.

If not previously vaccinated, HPV vaccination should be provided for 9-26 year olds following sexual assault. An HPV vaccination series is also recommended for unvaccinated patients through age 26 years old.

HBV infection can be prevented by using post-assault immunization and immunoglobulin treatment (HBIG).

See <http://www.cdc.gov/std/tg2015/hepatitis.htm#table5> for further information.

7. Drug Facilitated Sexual Assault Testing

If the victim's history or symptoms indicate the possibility that drugs were used to facilitate the assault, and it is within 96 hours of the possible ingestion, collect evidence for the NYS Drug Facilitated Sexual Assault Kit. History or symptoms may include: memory loss or lapse, disheveled or missing clothing, dizziness, or intoxication that is disproportionate to the amount of alcohol reportedly ingested. The kit includes two gray-top blood tubes and a sterile urine specimen container. A consent form, which is included in the kit, should be completed. For further information see these web sites: www.criminaljustice.ny.gov/ofpa/pdfdocs/dfsalertsheetsheet.pdf (PDF) and www.criminaljustice.ny.gov/ofpa/evidencekit.htm.

References

- Adams JA, Kellogg ND, Farst KJ, Harper NS, Palusci VJ, Frasier LD, Levitt CJ, Shapiro RA, Moles RL, Starling SP. Updated guidelines for the medical assessment and care of children who may have been sexually abused. *J Pediatr Adolesc Gynecol*. 2016 Apr; 29(2):81-7. doi: 10.1016/j.jpag.2015.01.007. Epub 2015 Feb 12.
- Black CM, Driebe EM, Howard LA, et al. Multicenter study of nucleic acid amplification tests for detection of *Chlamydia trachomatis* and *Neisseria gonorrhoeae* in children being evaluated for sexual abuse. *Pediatr Infect Dis J*. 2009; 28(7):608-13.

- Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015. *MMWR Recomm Rep* 2015;64(No. RR-3):1-137. <http://www.cdc.gov/std/tg2015/tg-2015-print.pdf>
- Christian CW. Timing of the medical examination. *J Child Sex Abus.* 2011 Sep;20(5):505-20.
- Gavril AR, Kellogg ND, Nair P. Value of follow-up examination of children and adolescents evaluated for sexual abuse and assault. *Pediatrics* 2012; 129:282-9.
- Jenny C, Crawford-Jakubiak JE and Committee on Child Abuse and Neglect. The evaluation of children in the primary care setting when sexual abuse is suspected. *Pediatrics.* 2013; 132; e558. <https://www.ncbi.nlm.nih.gov/pubmed/23897912>
- Papp JR, Schacter J, Gaydos C, Van Der Pol B. Recommendations for the laboratory-based detection of *Chlamydia trachomatis* and *Neisseria gonorrhoeae*—2014. Centers for Disease Control and Prevention. *MMWR Recomm Rep.* 2014 14; 63(RR-02):1-19.
- Seña AC, Hsu KK, Kellogg N, Girardet R, Christian CW, Linden J, Griffith W, Marchant A, Jenny C, Hammerschlag MR. Sexual assault and sexually transmitted infections in adults, adolescents and children. *Clin Infect Dis.* 2015 Dec 15;61 Suppl 8:S856-64.
- Thackeray JD, Hornor G, Benzinger EA, Scribano PV. Forensic evidence collection and DNA identification in acute child sexual assault. *Pediatrics.* 2011 Aug;128(2):227-32. doi: 10.1542/peds.2010-3498. Epub 2011 Jul 25. PMID:21788217 <https://www.ncbi.nlm.nih.gov/pubmed/21788217>

Post-Assault Testing and Treatment Guidelines

Medical Care	Hours				Weeks		Months					
	24	48	96	120	1	2	1	2	3	4	6	12
1 Acute & Follow-up Examinations	Initial exam as soon as possible after exposure or disclosure				Follow-up Exam 1 to 2 weeks		Exams for physical and emotional well-being may be done at any time. Examine at 1-2 months to re-evaluate for presence of anogenital warts.					
2 Forensic Specimen Collection	Case-by-case											
3 HIV Post-Exposure Prophylaxis & Testing	NYS 36 hours	CDC 72 Hours					Re-test 4 to 6 weeks		Re-test 3 months			
4 Pregnancy Testing & Prevention					Follow-up Serum β hCG 1 to 2 weeks							
5 STI Testing				GC/Chlamydia testing	Follow-up cultures 1 to 2 weeks		RPR, HBV 4 to 6 weeks		RPR, HBV, 3 months			
6 STI Treatment	Treatment may be offered in the acute post-assault setting. Treatment decisions are guided by results of diagnostic testing.											
7 Drug Facilitated Sexual Assault Testing												

V. March 2019