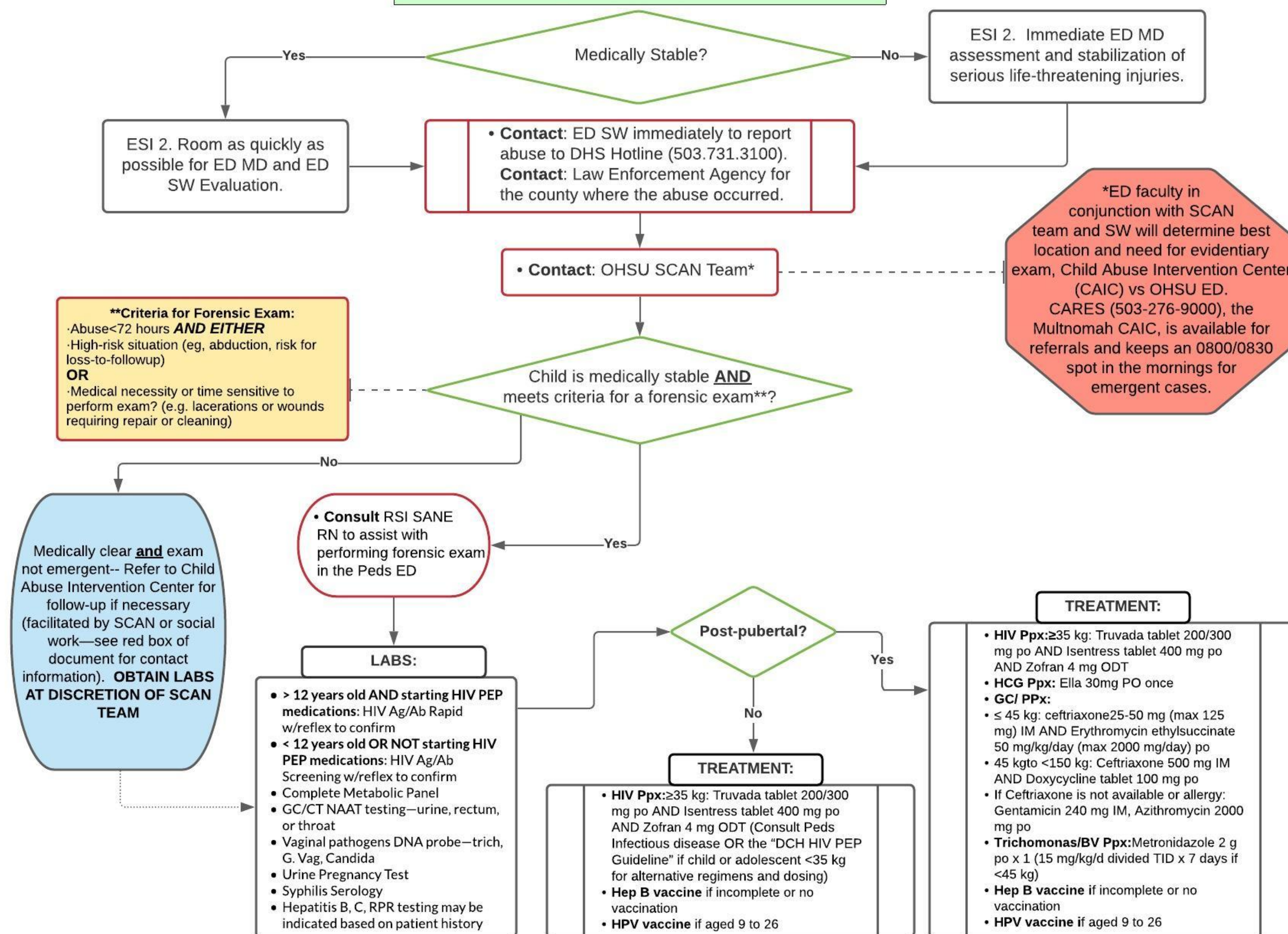
Pediatric (<15 years of Age) Sexual Assault Clinical Pathway

November 2021



Special Notifications:

1. Notify ED social worker for all sexual assaults <18 years of age. This is regardless of whether full exam completed or not.
2. PEM admin is on-call for problem solving
3. SCAN TEAM MUST be ***notified for all sexual assaults*** <18 years of age.
4. Exam will be completed by RSI or RSI/ED but SCAN team needs to be notified and aware of patient and final disposition.

***To Get MEDIA Cards back**: contact Aaron Bieleck with HIM ED COMM 4-7621.

**During Modified Operations—all media cards are sent to Dr. Valvano and will be returned by him. Email the Peds ED ANM and she/he will take the card to Dr. Valvano's office

1. **<u>Clinician Provider: Physical Examination:</u>**
    a. Skin
        i. Inspect all areas with child unclothed/in gown
        ii. Document bruises, petechiae, abrasions, lacerations, scarring pattern injuries (bite marks or suction bruises), other marks. Note distinct shapes of recognizable objects, patterns, distribution, and concerning areas of injury (eg, non-exposed areas such as buttocks, thighs, genitals, ears, and frenulum).
    b. Eyes
        i. If abusive head trauma is suspected, do fundoscopic exam or consult ophthalmology
    c. Oral Exam
        i. Document lacerations, abrasions, petechiae, ecchymoses
        ii. Check mucosa, palate, upper and lower frenula, tongue, gums, lips, teeth for signs of injury
    d. Abdomen
        i. Look for bruises, abrasions; consider associated intra-abdominal injury
    e. Anogenital Exam – General
        i. Procedural sedation is rarely needed; try reassurance, emphasis on privacy, eliciting child's concerns. *In the rare instance that procedural sedation is required, consider inpatient admission and discussion with the admitting team for the appropriate time and location for this exam.*
        ii. If genital exam is not possible, swabs from abdomen and umbilicus may be used to obtain DNA
        iii. Use a good light source & magnification
    f. Genital Exam – Female
        i. Child should be examined in supine frog leg or dorsal lithotomy position and the prone knee-to-chest position
        ii. Gently apply labial separation and traction for visualization
        iii. Speculum exam not indicated in prepubertal or early pubertal girls
        iv. Examine inner thighs, mons pubis, labia majora and minora, inner labial wall, hymen, posterior fossa, posterior fourchette, perineum
        v. Document hymeneal features (morphology, edges, notches, clefts, mounds, projections, transection, absence of tissue, acute laceration or ecchymosis, healing injuries)
    g. Genital Exam – Male
        i. Document penile, scrotal or perineal abrasions, ecchymoses, lacerations, petechiae or other marks, edema, discharge, erythema, tenderness, inflammation
    h. Perianal/Anal Exam
        i. Anal fissures, visible laxity or dilatation (and note the presence or absence of stool in the rectal vault), irregularity of orifice, scarring, abrasions, lacerations, tenderness, edema, discharge, erythema, condylomata acuminata, skin tags, hemorrhoids.
        ii. Digital rectal exam not necessary, unless concern for foreign body
        iii. If anoscopy is indicated for anal bleeding or rectal pain after penetration, perform after forensic evidence collection

2. **<u>Forensic Evidence Collection (SANE RN):</u>**

A. <u>Pubertal</u> - >Tanner Stage 1 or approximately 8 years of age

Sexual Assault Forensic Evidence (SAFE) Kit –

<u>Chain of Custody</u>. Once opened, the forensic specimen kit and its contents must be in ***continuous physical possession of the examining provider*** (RSI RN should maintain evidence package chain of custody). Once the

evidence has been collected, the specimens must be transferred immediately to law enforcement official custody.

General Guidelines

- Sterile cotton swabs should be used.
- To swab dry areas, lightly moisten swabs with sterile water; to swab wet areas, use dry sterile swabs. Swabs must be thoroughly dried before packaging. Dry and wet swabs are required for each site. Wet swab first then dry swab.
- Create pre-made labels that delineate site of specimen collected.
- Never lick an envelope to seal; use tape, adhesive seal or patient ID label. Sign over the seal, and place specimen in Evidence Kit.
- Do not discard unused envelopes; label and place in box and indicated why not collected

Step 1 Clothing Collection

- Clothing worn at and after time of abuse, particularly undergarments and any stained or damaged clothing
- Collect undergarments, even if changed since assault**
- Have clothing removed while patient is standing on exam paper. Collect each piece of clothing and place in **separate paper bags**. Bags should be clearly labeled with a patient label and dated and RN initials. Clear description on the outside of each bag. Carefully fold the exam paper and place in a separate paper bag, labeled, and dated with RN initials.

Step 2 Oral Swabbing

1. Consider routine collection for assault within 12 hours, or visible injury. Use 2 swabs at a time (4 total) to swab around buccal mucosa, under tongue, and along inferior gum line. Use 4 more swabs vigorously along the inner cheek to establish patient DNA.

Step 3 Woods (UV) lamp examination

1. Collect sample with sterile-water moistened swab for any area that fluoresces.
2. Smear a slide in a dime-size area with swab after collection
3. Air dry the swab and slide before placing in evidence envelope and slide holder.

Step 4 Skin Swabs after Oral Contact

1. For any reports of mouth on skin contact, swab each area with lightly moistened cotton swab.
2. Label each area separately and place in individual, labeled envelopes.

Step 5 Skin, Hair and Nails

1. When assault occurred within 72-96 hours and child has not bathed, swab skin around dried secretions, bite or suction marks, and any areas that fluoresce under Wood's lamp. Comb pubic hair if present and if patient has not bathed/showered after event, collect any debris or foreign hair, place comb in labeled envelope. If debris or blood under nails, scrape onto paper and place folded paper and scraper in labeled envelope.

Step 6 Anogenital Swabbing

1. Consider external and internal genital swabbing (up to 4 swabs each) within 72-96 hours of assault.
2. Intravaginal / cervical swabbing is rarely indicated for prepubertal girls. If obtained, insert swab gently through hymenal opening, taking care to avoid touching the hymen. For adolescent girls who have not had a speculum exam, obtain samples by inserting swabs into the vagina.
3. Do not use lubricant for speculum exams; use warm water for comfort.

4. Consider routine collection from perianal areas within 48 hours of assault. Collect rectal swabs if there is anal injury or reported contact. Insert one lightly moistened cotton swab approximately 2 cm past the anal sphincter. Collect up to 4 swabs from each location.

2. Forensic Evidence Collection (SANE RN):

B. Pre-pubertal - < 8 years old or Tanner Stage I

Sexual Assault Forensic Evidence (SAFE) Kit –

Chain of Custody. Once opened, the forensic specimen kit and its contents must be in continuous physical possession of the examining provider. Once the evidence has been collected, the specimens must be transferred immediately to law enforcement official custody.

General Guidelines

- Sterile cotton swabs should be used. To swab dry areas, lightly moisten swabs with sterile water; to swab wet areas, use dry sterile swabs. Swabs must be thoroughly dried before packaging.
- Create pre-made labels that delineate site of specimen collected.
- Never lick an envelope to seal; use tape, adhesive seal or patient ID label. Sign over the seal, and place specimen in Evidence Kit.
- Do not discard unused envelopes; label and place in box and indicated why not collected

1. Pre-pubertal kits are simplified kits for children <8 years old or Tanner State I. Review steps above. Pre-pubertal kits are simplified but the procedure for collecting is the same.
2. Evidence will only be collected if contact occurred within the last 24 hours. This however is a Guideline. There may be circumstances where it is reasonable to complete the kit beyond 24 hours (i.e. clear history of penetration and/or ejaculation with minimal bathing that occurred at 30 hours).
3. Always collect unwashed clothing, including underwear beyond the 24 hour mark.
4. Only make slides from swabs that may contain ejaculate (usually the genital slides).
5. Do **NOT** make slides from swabs that contain only saliva
6. Include reason for collecting the swab on each envelope ("swab from left breast because pt reports being licked there"). This aids forensics lab in understanding what they are looking for
7. When breasts are swabbed they should be swabbed and labeled separately. Each contact with each breast represents a separate crime.
8. It is **NOT** necessary to collect oral sodomy slides from the mouth if >12 hours has passed since the event. Instead collect as DNA standard (which is done on every patient)
9. Photo documentation of visible or bruising wounds, marks or injuries. Follow OHSU photo documentation policy.
10. Maintain Chain of Evidence as outlined above.

Pubertal SAFE Kit contents (≥8 years to Adult)	**Pre-pubertal SAFE Kit contents (< 8 years or Tanner Stage I)**
Vaginal Swabs Cervical Swabs Oral Swabs Pubic hair combings Pubic hair standards Head hair standards Comb 2 slides and mailers Sterile swabs Instructions/FLIF Crime Victims Reimbursement Form	Inner genitalia swab Outer genitalia swab Rectal/perianal swab Oral swab Body swab x 2 2 slides and mailers Sterile swabs Instructions/FLIF

3. **Photographic Evidence Collection (Clinical Provider)**
   - Photographs **should be collected** for all sexual assault exams, like they are for physical abuse documentation.
   - Photographs should be obtained of genitalia and any visualized marks, bruises, or other injuries.
   - Sexual assault photos should be taken per policy HC-RI-121-POL, which requires the following:
     - i. Attending MD to take photo documentation
     - ii. Verify date on camera is correct, so the time stamp of photos is correctly matched
     - iii. Only 1 patient per camera card (DO NOT Save to camera)
     - iv. Include patient ID sticker in each photograph:
       1. First image patient label
       2. Full picture of patient
       3. Patient a little closer
       4. Area(s) of documentation with and without a ruler
       5. Full picture of the patient
       6. Image of patient label
     - v. Secure memory card in envelope, sign envelope, and follow Digital Storage and Retrieval of Electronic Images policy: HC-RI-121-POL
     - vi. RN/CNA/Tech may take media card to BICC room 104—David Gunn and Aaron Bieleck are the contact people (47621) → chain of custody must be maintained, sign off is required for handing off between persons
     - vii. During Modified operations, Media card is taken to Dr. Valvano's office (CDRC 1272E)

Karly's Law

Children with suspicious physical injuries must be referred to a child-abuse-trained designated medical professional (CAIC) for evaluation and determination. For follow-up referrals >48 hours from time of original presentation suspicious injuries must be photo documented in accordance to Karly's Law, ORS 419B.022-419B.024.

4. **Diagnostic Testing: (Please use ED: Sexual Assault order set)**

   a. Urine pregnancy test for females ≥10 years, any menstrual periods/Tanner stage 3
   b. Toxicology: for drug-endangered children, obtain 10-20 mL urine sample and send for drug screen. Other specific drug testing (heavy metals, alcohols) as indicated. Toxicology testing for medical care should be sent to hospital lab. Toxicology testing for medical-legal purposes should follow chain of custody. Call the on-call toxicologist with any specific questions about urine or serum testing for drug levels.
   c. STD testing:
      - i. In the ***acute setting***, obtain:
        1. HIV screening: HIV testing is generally not required in the ED and may be deferred for follow up; if PEP is to be given, obtain baseline HIV test. ***Do not start PEP therapy on pediatric patients without consult with Peds Infectious Disease***.
           a. > 12 years old AND starting HIV PEP medications: HIV Ag/Ab Rapid w/reflex to confirm for ED
           b. < 12 years old OR NOT starting HIVI PEP medications HIV Ag/Ab Screening w/reflex to confirm
        2. Complete Metabolic Panel
        3. GC/CT NAAT testing—urine, rectum, or throat
        4. Vaginal pathogens DNA probe—trich, G. Vag, Candida
        5. Urine Pregnancy Test
        6. Syphilis Serology
        7. Hepatitis B, C, RPR testing may be indicated based on patient history.

   ii. Swab any vesicular or ulcerative genital or perianal lesions that are suspicious for genital herpes and send for viral culture

d. Additional lab and radiology testing
   i. Radiographic studies should be obtained as indicated for suspected non-accidental trauma

5. <u>Treatment: (Please use ED: Sexual Assault order set)</u>

a. Ella (Ulipristal) tablet 30 mg po once. Offer to post-menarchal patients when:
   i. Assault took place within the last 120 hours
   ii. Patient is not using a highly reliable method of birth control
   iii. Any pregnancy conceived in the last 5 days would be undesirable to continue
   iv. Pregnancy test is negative

b. HIV Prevention: for adolescents and adults ≥35 kg (Consult Peds Infectious disease OR the “DCH HIV PEP Guideline” if child or adolescent <35 kg for alternative regimens and dosing)
   1. IN ED: Truvada tablet 200/300 mg po AND Isentress tablet 400 mg po AND Zofran 4 mg ODT
   2. Discharge with one-month supply of each medication
   3. Follow Up Plan:
      a. <18 years: Consult Pediatric Infectious Diseases CNSLT0102 (Please page the attending on call prior to discharge to ensure the outpatient consult is triaged urgently)
      b. ≥ 18 years: Consult order to “IMC HIV” CNSLT0336 (Please include the Internal Medicine Clinic phone number in the discharge instructions and ask the patient to contact the clinic if they don’t hear from someone the next day: 503.494.8562)

c. STD prophylaxis is <u>not</u> routinely recommended to prepubertal children and may interfere with future investigation. Post-menarchal patients should be offered prophylaxis for STD’s in case of genital-genital contact. The recommended regimen is:
   i. For gonorrhea and Chlamydia:
      1. ≤ 45 kg: ceftriaxone 25-50 mg (max 125 mg) IM AND Erythromycin ethylsuccinate 50 mg/kg/day (max 2000 mg/day) PO
      2. > 45 kg to <150 kg: Ceftriaxone 500 mg IM AND Doxycycline tablet 100 mg PO (if ≥8 years old and NOT pregnant); *if <8 years old or pregnant* Azithromycin 1000 mg PO
      3. If Ceftriaxone is not available or allergy: Gentamicin 240 mg IM, Azithromycin 2000 mg PO
      4. >150 kg: Ceftriaxone 1 Gram IM AND Doxycycline 100 mg PO (if not pregnant, if pregnant then Azithromycin 1000 mg PO)
   ii. For Trichomonas/Bacterial vaginitis: Metronidazole 2 g po x 1 (15 mg/kg/d divided TID x 7 days if <45 kg)

d. Hepatitis B vaccine should be offered, along with instructions for need for repeat doses if patient has not been fully immunized for Hepatitis B or if patient is unvaccinated or known to not have responded to the Hep B series, and secretion-mucosal contact occurred during the assault

e. HPV vaccine should be offered to **all patients aged 9 to 26 years old**, with instructions for need for repeat doses if patients has not been fully immunized for HPV or if patient is unvaccinated.

6. <u>Oregon Strangulation Forensic Evidence Kit (SKIT):</u>

- IP Consult to RSI/SANE RN
- Can be part of sexual assault work up or alone
- http://oregonsatf.org/strangulation-forensic-evidence-kit/
- Just in time Training Video if SANE RN not available: https://www.youtube.com/watch?v=a-x2JU6YAE4

- Each kit contains the necessary documentation, forensic evidence collection swabs, and imaging recommendations for the provider.

7. **Disposition and Follow-up:**

   a. If, in consultation with DHS, it is determined that a patient cannot be discharged to a safe environment, **Admit**
   b. Ensure appropriate calls were made to DHS and/or law enforcement
   c. Arrange appropriate medical follow-up for STDs, pregnancy, physical injuries and counseling:

Patient lives in Multnomah/Washington County, abuse occurred in Multnomah/Washington County:	Patient lives in another county in Oregon	Patient lives in state of Washington, abuse occurred in Washington
Referral to CARES NW, follow up to be arranged by child abuse social worker (at CARES) 503-276-9000	Refer to local Child Abuse Intervention Center (CAIC) See www.childabuseintervention.org/centers.cfm for local contact information	Refer to local Child Abuse Intervention Center (CAIC) 360-397-6002

8. **Expert Review:**
   a. By Karly's Law, review of the case by a Designated Medical Professional must occur within 48 hours.
   b. The medical chart must be dictated "STAT" with a cc to CARES NW. Chart and photos are to be sent to CARES NW w/in 48 hours of presentation.

References:

1. Reichert S, Keltner L, Reilly P, Skinner S., eds. Oregon Medical Guidelines for Evaluation of Sexual Abuse in Children and Adolescents. Oregon Department of Justice Crime Victims' Assistance Section. Salem, Oregon. 2004. Available at http://www.doj.state.or.us/crimev/pdf/ormedicalguidelines.pdf
2. Defining the Children's Hospital Role in Child Maltreatment. National Association of Children's Hospitals and Related Institutions.
3. Centers for Disease Control and Prevention. Sexually Transmitted Diseases: STD Treatment Guidelines 2006. MMWR.
4. CDC Sexually Transmitted Diseases Treatment Guidelines 2006: Sexual Assault or Abuse of Children. Accessible at: http://www.cdc.gov/std/treatment/2006/sexual-assault.htm#children
5. Centers for Disease Control and Prevention. A comprehensive immunization strategy to eliminate transmission of hepatitis B virus infection in the United States: recommendations of the Advisory Committee on Immunization Practices (ACIP); Part 1: Immunization of Infants, Children, and Adolescents. 2005. MMWR.
6. Kellogg N, American Academy of Pediatrics Committee on Child Abuse and Neglect. The evaluation of sexual abuse in children. Pediatrics 2005;116:506–12.
7. Lahoti S, McClain N, Girardet R, McNeese M, Cheung K. Evaluating the Child for Sexual Abuse. American Family Physician 2001; 63(4): 883-892.
8. A National Protocol for Sexual Assault Medical Forensic Examinations: US Department of Justice Office on Violence Against Women. September 2004. Accessible at : http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf
9. Practice Parameters for the Forensic Evaluation of Children and Adolescents who may have been Physically or Sexually Abused. American Academy of Child and Adolescent Psychiatry, 1996. Accessible at: http://www.aacap.org/galleries/PracticeParameters/Forensic.pdf

10. Legacy Emanuel Emergency Department, “Management of Pediatric Patients Presenting to the Emergency Department with Suspected Abuse,” revised October, 2004.
11. Seattle Children’s Hospital and Regional Medical Center, “Sexual Assault Emergency Medical Evaluation: Child 12 Years and Under,” 2005.

Resources:
Detailed recommendations for the management of suspected sexual abuse in children is available at:
http://www.doj.state.or.us/crimev/pdf/ormedicalguidelines.pdf. (reference 1, above).

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