PEDIATRIC EMERGENCY DEPARTMENT CLINICAL GUIDELINE:
EVALUATION OF SEXUAL ABUSE OR ASSAULT

General Definition:
- “The involvement of children or adolescents in sexual activity they do not understand, to which they cannot give informed consent, or that violates social taboos.”

Presentation:
- Disclosure or outcry
- Physical complaints related to the abuse (i.e. vaginal discharge, rash, bleeding)
- Medical evaluation after report made to police or DCFS

How do I contact SW?
- PER social work pager: 8887
- PER has on-site social work coverage 40 hours per week.
- PER social workers are available for phone consultation only when off-site. Review the case with the attending prior to calling SW after hours as SW is not available at bedside after hours.
- The social workers assist with history taking, reporting, management, and can advise the medical providers about management and disposition for on-site cases.

History:
- Minimize interview of patients 3-12 years old. These children will get an FI (forensic interview) through DCFS so no need to re-interview if disclosure made to caretakers.
- If social work is on-site, they take the history and you augment with medical questions.
- If social work is not on-site, you are responsible for taking a history
- Interview the child and the caretaker separately unless the child refuses to separate from parent.
- Interview the caretaker first. Obtain demographics and details of the abuse or concern.
- Document the history using quotes as often as possible
- If necessary to interview the child who has made no disclosure, minimize your interview to necessary information such as brief disclosure of the abuse, timing, and medical symptoms:
  - Take the history in an accepting manner – sexual abuse is not always viewed by the child as traumatic so expressing shock or dismay could be harmful to their mental state or perception
  - Ask open-ended, non-leading questions (“What happened?” or “Tell me why you are here”)
  - Avoid specific, leading questions – if they disclose details, gently prompt with “tell me more”
  - Document what they freely offer and do not ask probing, detailed, leading questions.

Physical Examination:
- 80-90% OF PHYSICAL EXAMS ARE NORMAL
- A NORMAL PHYSICAL EXAM DOES NOT RULE OUT SEXUAL ABUSE

Preparation:
- Describe the exam to the caretaker and the patient before starting.
- Do the exam with a supportive adult present (non-offending caretaker, nurse, etc).
- Have the patient get completely undressed and into an exam gown. If forensic evidence is being collected, do not have the patient get undressed as clothing collection is part of the forensic kit.
- Perform the general physical exam first before the genital exam.
- The ED attending should be present for the genital exam.
Positions:
- Pre-pubertal females
  - Supine frog-leg position on exam table or lithotomy on caretaker's lap
  - Prone knee-chest position if abnormality seen to verify presence in two positions
- Pubertal / Adolescent females - lithotomy on pelvic table (move patient to Exam room 16)
- Males - lying or standing
- All - supine knee chest position to examine anal/perianal area

Technique:
- Examine the external genitalia for signs of injury or infection.
- Examine the internal genitalia by visual exam
  - In general, speculums are NOT necessary for a visual genital exam for traumatic injury.
  - If you feel a speculum exam is needed, discuss this with the attending prior to proceeding.
- Use the labial separation and labial traction techniques
- Moisten swabs with sterile saline prior to obtaining samples

Findings and Documentation:
- **Female:**
  - Scars, bruises, lacerations, lesions, or rash on the external genitalia or perineum
  - Presence or absence of hymenal tissue
  - Presence or absence of mounds, notches, lacerations, abrasions on hymenal rim
  - Location of findings using a clock face (urethra 12 o'clock and posterior fourchette 6 o'clock)
- **Male:**
  - Scars, bruises, lacerations, lesions, rash, or discharge on the penis, scrotum, and perineum
- **Anal / Perianal area:**
  - Visual assessment of anal tone
  - Presence or absence of scars, bruises, lacerations, bleeding, lesions, ulcers, or rash.

Forensic Evidence Collection Kit:
- Sexual abuse / assault occurred less than 7 days ago AND
- Contact with perpetrator’s genitalia, saliva, blood (i.e. nature of assault suggests seminal fluid, pubic hair, saliva, or blood of the perpetrator may be recovered)
- In a pre-pubertal child, literature supports evidence collection only out to 5 days.

STI testing:
- **Indications:**
  - Symptoms concerning for STI (by history or exam)
  - History of contact with perpetrator’s genitals (includes anal, vaginal, penile, and oral contact)
  - Genital trauma noted on exam
  - Another child in home with STI due to sexual abuse
- **Orders & Collection:**
  - Gonorrhea and Chlamydia – Aptima testing can be done on all ages from all sites as below.
    - **Patients ≥ 14 years old:**
      - Urine - Collect and place in ONE URINE Aptima transport tube.
      - Oropharyngeal swab – ONE Unisex APTIMA swab in APTIMA transport tube.
      - Rectal swab – ONE Unisex APTIMA swab in APTIMA transport tube.
    - **Patient < 14 years old** (lab needs TWO Aptima samples from each site)
      - Urine - Transfer specimen into TWO URINE Aptima transport tubes
      - Oropharyngeal swabs - TWO Unisex APTIMA swabs in TWO Aptima transport tubes.
      - Rectal swabs - TWO Unisex APTIMA swabs in TWO Aptima transport tubes.
  - Hepatitis B & C – Acute Hepatitis Panel AND Hepatitis B Surface AntiBODY
  - HIV – HIV1/HIV2 Antibody (written consent NO longer required, just verbal consent)
  - Syphilis – RPR Screening Antibody
STI treatment / prophylaxis:
- Gonorrhea & Chlamydia
  - If ≥ 45kg: Ceftriaxone 250 mg IM X 1 AND Azithromycin 1 gram PO X 1
  - If < 45kg: Ceftriaxone 125 mg IM X 1 AND Azithromycin 20 mg/kg PO X 1
- Trichomoniasis & Bacterial Vaginosis
  - If ≥ 45kg: Metronidazole 2g PO X 1
  - If < 45kg: Metronidazole 30mg/kg PO x 1
- Syphilis: No empirical treatment warranted
- ANY alternative regiments SHOULD BE discussed with Peds ID Fellow on call (pager 4784)
- HIV, Hepatitis B and C Post-exposure prophylaxis
  - SEE Comer ER Non-occupational Exposure to Bloodborne Pathogen Guidelines

Pregnancy prophylaxis/Emergency Contraception:
- Only effective within 72 hours of the assault
- Plan B One-Step – 1.5 mg levonorgestrel PO x 1 in ED prior to discharge
- Please document negative pregnancy test prior to administering.
- In patients with BMI > 25, Plan B is NOT effective at preventing pregnancy. Please prescribe Ella 30 mg PO X 1.

Reporting / Investigation:
- Is the alleged perpetrator in a caretaker capacity or living in the home?
  - Yes → report to DCFS AND POLICE
  - No → report to POLICE ONLY
- How do I contact them?
  - Illinois DCFS → 800-25-ABUSE
  - Police → Call 911 for a police officer to come and take a report
- What information does the hotline need (be prepared so you do not waste time on the phone)?
  - Name, DOB, and address of the patient/victim, parents/caregivers, any siblings
  - Name, DOB/age, and address of the alleged perpetrator
  - Allegation, including any disclosure
  - Child’s condition, including any injuries

Disposition and Counseling:
Determination of safety
- Is the caretaker present a potential perpetrator OR is the perpetrator in the home?
  - YES – Request an emergency response from DCFS
  - NO – Will the caretaker be appropriately protective?
    - YES – Closing discussion and discharge
    - NO – Request an emergency response from DCFS

Closing discussion with parent / caretaker:
- Inform the caretaker or patient of any results of the evaluation and any reports to DCFS or police.
- Advise the caretaker that patient should not have contact w/the alleged perpetrator until cleared by DCFS and/or CPD.
- Provide the caretaker with counseling resources (bottom drawer of file cabinet)
  - CASA Parent Pamphlet – After Sexual Assault/ Abuse
  - Chicago Children’s Advocacy Center brochure

DISCLAIMER:
This clinical guideline has been developed for the purpose of unifying the general emergency care of patients with suspected sexual abuse or assault. It is intended to aid, rather than substitute for, professional judgment. It is not intended to serve as a rigid protocol or a written proxy for the standard of care. Failure to comply with this guideline does not represent a breach of the standard of care.