# Pediatric Sexual Abuse/Assault Management

Patient < 14 years[a] with concern for sexual abuse/assault

**Residents who have completed trauma-informed care training MAY:**

- Sign up for potential P-SANE patients after discussion with the PEM attending.
- Take HPI from the caregiver in private (NOT in the presence of the patient).
- Ask the patient how their body feels, if they are having pain, etc.
  Do NOT ask the patient leading questions
  (Example: "Did someone touch you? Did something hurt you?").
  Do NOT ask the patient specific questions about what may or may not have happened.[b]
- Do a basic physical exam *excluding* GU exam.
- Tell the family that next steps will be discussed with the attending physician.

Perform Medical Screening Exam[c]

**Presence of any of the following:[2]**

- Witness to or disclosure of assault that may have resulted in transfer of genetic material within the last 72 hours[d]
- Or debris/body fluids visible on the patient's body/clothing
- Or an acute genital/anal injury concerning for sexual abuse/assault

**No**

- Place Hotline to DFS
- Referral to Child Advocacy Center at Rainbow House

**Yes**

- Consult P-SANE for Sexual Assault Forensic Exam (SAFE)
- P-SANE will assist with placing hotline and referring to Child Advocacy Center at Rainbow House

Child refuses SAFE

- **Yes** → No SAFE
- **No** → P-SANE perform SAFE

**Page 2:**

- Indications for STI testing
- Indications for STI prophylaxis

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**Indications for STI Testing:**[3]

Postpubertal patients

Or prepubertal patients with any of the following:

- History of penetration or child unable to provide details
- Acute genital, anal and/or oropharyngeal injury
- Assault by a stranger or perpetrator known to be high risk for STIs[e]
- Genital symptoms (ex: discharge, pain) or lesions (ex: vesicles, warts) concerning for STIs
- Patient or family request

No → STI testing not indicated

Yes →

**Obtain STI Tests:**

Non-clean/"dirty catch" urine sample for GC/chlamydia NAAT and trichomonas NAAT

**If evidence of injury or report of penetration:**

GC/chlamydia mucus membrane NAAT swabs (ex: pharyngeal, rectal, vaginal) and trichomonas vaginal NAAT swab

Blood sample for HIV 1,2 Ag/Ab, syphilis IgG/IgM Ab, Hepatitis C Ab

If not Heb B immunized: Hepatitis B surface Ag, Hepatitis B surface Ab, Hepatitis B core Ab IgM

**Consideration of Prophylactic STI Treatment:**

Postpubertal patients

Or prepubertal patients with any of the following:

- Symptoms suggesting STI
- Oral, genital, and/or anal injury
- Assault by a stranger or perpetrator known to be high risk for STIs
- Concern for sex trafficking[4]

Substantial HIV risk exposure[f]

No → STI treatment not indicated

Yes[g] →

Ceftriaxone 50mg/kg (max 500mg) IV or IM

Doxycycline 2.2 mg/kg (max 100mg) PO BID x 7 days

Metronidazole (weight/sex-based dosing)[h]

Consult Peds ID for prophylactic treatment recommendations if substantial HIV risk exposure[f]

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**Footnotes:**

a. Patients 14 years and older presenting due to concern for sexual abuse/assault can be managed by adult sexual assault nurse examiner (SANE).[1] Hotline and referral to Rainbow House is typically indicated for all children < 18 years.
b. As soon as it is determined that the reason for the ED visit is for a forensic exam, it is critical that no further questions be asked by anyone other than the P-SANE or ED attending about the abuse/assault. It is critical to minimize the re-telling of the event. Children will be referred to the Child Advocacy Center where a forensic interview will be performed by a forensic interviewer with children developmentally cabaple.[1,2]
c. A medical screening exam performed by a physician is required at the presenting facility to determine if there are any injuries to the child requiring medical intervention and to determine if the child should have an emergent exam or be referred to Rainbow House or appropriate Children's Advocacy Center.[1]
d. Transfer of genetic material is suspected in cases of contact with a perpetrator's mouth, genitals, or blood. SAFE may be performed in situations in which a child is unable to provide details of the alleged assault if presence of forensic evidence is still suspected.
e. Perpetrators considered high risk for STIs includes injection drug users, males who have sex with males, persons with multiple sex partners, and/or a history of STIs.[4]
f. Substantial HIV risk exposure: Exposure of vagina, rectum, eye, mouth/other mucous membrane, and/or nonintact skin/percutaneous contact with blood, serum, vaginal secretions, rectal secretions, breast milk, or any body fluid that is visibly contaminated with blood when the source is known to be HIV positive and/or high risk (men who have sex with men, injection-drug user, commercial sex worker, or assault involving multiple assailants or multiple exposures to the same assailant).[6]
g. Vaccination against Hepatitis B and HPV is recommended if not fully immunized.[4]
h. Metronidazole prophylaxis is recommended for postpubertal females. Dosing recommendations:[7]
    a. Children <45 kg: 45 mg/kg/day in divided doses every 8 hours x 7 days (max daily dose 2,000 mg/day)
    b. Children ≥45 kg and adolescents:
        a. Females: 500 mg q 12 hours x 7 days
        b. Males: 2,000 mg as a single dose

**References:**

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