

Emergency Department Assessment of Children and Teen Victims of Sexual Abuse

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Objectives

- *Recognize common presentations of sexually abused children*
- *Dispel myths related to sexual abuse*
- *Recognize the indications for evidence collection*
- *Know how to report suspected abuse*
- *Know how to obtain additional consultation*

Child Sexual Abuse

- “Occurs when a child is engaged in sexual activities he/she cannot comprehend, for which he/she is developmentally unprepared and cannot give informed consent and which violate social and legal taboos.” (Kempe, 1978)

Child/Teen Sexual Abuse Statistics

- 9.3% of cases of maltreatment of children in 2012 were classified as sexual abuse.
- 62,939 cases of child sexual abuse were reported in 2012
- Research conducted by the Centers for Disease Control (CDC) estimates that approximately 1 in 6 boys and 1 in 4 girls are sexually abused before the age of 18
- Teens 16 to 19 years of age were 3 ½ times more likely than the general population to be victims of rape, attempted rape, or sexual assault

Common Presentations for Child and Adolescent Sexual Abuse

- Disclosure
- Injury
- Sexually Transmitted Disease
- Concerning Signs and Symptoms

Child Sexual Abuse Disclosure

- Not all sexually abused children exhibit symptoms (physical or emotional)
- Often delayed
- “Is often a process rather than a single event”
- Adult response to the disclosure matters
- The relationship to the perpetrator, age at first incident of abuse, use of physical force, severity of abuse, and demographic variables, impact a child’s willingness disclose

Reporting Child Abuse and Neglect

- Healthcare providers are mandated reporters of suspected child abuse and neglect.
- To make a report, call the Child Protection Hot Line or the Protection and Permanency office in your county.
- **Child Protection Hot Line: 1-877-KY-SAFE1 (597-2331)**

Examination Logistics

- Nature of abuse, timing and chronicity is important in determining where and when the examination should be performed, whether forensic evidence collection is necessary, and what tests should be sent.

Indications for acute exam

- Assault within 96 hours and/or forensic evidence may need to be collected
- Acute pain, bleeding
- Suicidal ideation
- Needs emergency contraception (up to 120 hours)
- Needs HIV post exposure prophylaxis (up to 72 hours)

Indications for an Urgent Exam

- Suspected or reported sexual contact that occurred within the last two weeks, without emergency medical, psychological and safety needs identified

Non urgent exam

- Suspected or reported sexual contact that occurred more than two weeks prior, without emergency medical, psychological and/or safety needs identified

Medical History

- Type of contact
- Most recent contact, if known
- Identity of perpetrator
- Symptoms

How should you proceed?

- Talk to caretaker without the child present
- Who was involved? (is the child safe in her current environment)
- When did it happen?
- When was the last contact with the perpetrator?
- What happened?
- Is the child having any symptoms and could these symptoms be related to the history of abuse?
- Has the abuse been reported?

Asking non leading questions about abuse

- Tell me why you think you are here today.
- Sometimes kids that come to see me tell me that something has happened to their bodies that they didn't like.
- Sometimes kids that come to see me tell me that something has happened to their bodies that made them feel uncomfortable.
- Do you know what the word inappropriate means? Sometimes kids that come to see me tell me that something has happened to their bodies that they thought was inappropriate. Has anything like that ever happened to you?

Do NO Harm

- Obtain consent/assent for exam

Purpose of the Medical Evaluation

- To identify evidence of injury
- To gather forensic evidence when appropriate
- To look for other explanations for medical findings
- To identify and treat infection
- To assess the child for any developmental, emotional, or behavioral problems needing further evaluation and treatment and make referrals if necessary
- To reassure the child and family, as appropriate

What to expect during a medical examination in the ER

- NO Speculum exam
- Possibly NO Shots
- Not painful
- ?Sedation
- We cannot force anyone to have an exam, but sometimes a reluctant teen can be convinced once educated about the exam
- Support person can be present
- Assessment for injuries
- Testing for STI's when indicated
- Collection of evidence when indicated
- Testing for pregnancy when indicated
- Mental health screening

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Identify Evidence of Injury

- Head to Toe Assessment including GU (no speculum).
- Assess oropharynx for frenulae injuries/palatal petechiae.
- Assess buccal mucosa for abrasions.
- Assess neck and breast.
- Assess for signs of strangulation (neck lesions, subconjunctival hemorrhage, facial petechiae, hoarseness).
- Assess/document areas of tenderness.
- If possible, perform clinical photography of injuries.

Sexually Abused Children and Medical Exams

- Many (in fact most) exams are normal.
- Sometimes unexpected findings have been identified that were helpful to either an investigation or the child's physical health and well being.

Distinguishing Myth from *Reality*

- A medical exam cannot always determine whether sexual abuse occurred
- Most sexual abuse leaves no visible scars
 - Perpetrators may avoid visible injury to the child
 - Hymenal tissue is elastic
 - Anogenital injuries heal rapidly
 - Many exams of children with STDs are normal
 - Many exams of children with acute trauma are normal within one week
 - Many exams of pregnant females are normal
 - Many exams of children whose abusers have confessed to penetration are normal

Distinguishing Myth from *Reality*

- A normal medical exam often can neither confirm nor discount a child's history of sexual abuse.
- Children and adolescents with a history of sexual abuse can have a normal examination.
- Children and adolescents with a history of penetration can have a normal examination.
- Child and adolescent victims who do not report physical symptoms may still have an abnormal examination.

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When is Forensic Evidence Collection Indicated?

- Likelihood of recovery of evidence probably different for prepubertal child as opposed to adult
- “72 hour rule” evolved as a result of data from a few studies showing that sperm could be recovered from the adult female genital tract up to 72 hours following penile vaginal intercourse
- ***Kentucky Statewide Medical Protocol uses 96 hours***

SEXUAL ASSAULT EVIDENCE COLLECTION KIT FOR FEMALE OR MALE VICTIM

1. PLACE ALL EVIDENCE COLLECTED IN KIT BOX.
2. SEAL KIT BOX WITH THE ENCLOSED SEALING LABEL, INCLUDE DATE, TIME AND INITIALS (INVESTIGATING OFFICER AND COLLECTOR).
3. SECURE KIT UNTIL IT CAN BE DELIVERED TO THE FORENSIC LABORATORY.

STEP 11
USING THE APPROPRIATE SET OF ANATOMICAL DRAWINGS, MARK AND DESCRIBE ALL BRUISES, BITEMARKS, ETC.

ANATOMICAL DRAWINGS
VICTIM'S NAME: _____

Forensic Odontologist consulted? Yes No

VULVA: _____
INTROITUS: _____
VAGINA: _____
CERVIX: _____
UTERUS: _____
ADNEXA: _____
HYMEN: _____
RECTUM: _____
ANUS: _____

Photographs Taken? Yes No
Forensic Odontologist consulted? Yes No

PERINEAL GENITALIA EXAMINATION - Note all signs of trauma, i.e. bruises, petechiae, discharges, sphincter tone. Also note any traces of lubricants or rectal soiling.

STEP 10 KNOWN BUCCAL STANDARD
VICTIM'S NAME: _____

STEP 9 30 PULLED HEAD HAIRS
VICTIM'S NAME: _____

STEP 8 CONTROL SWABS

STEP 7 OTHER EVIDENCE
VICTIM'S NAME: _____

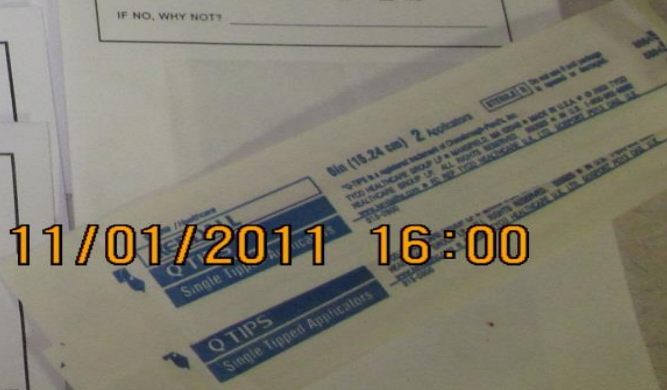
STEP 7 OTHER EVIDENCE
VICTIM'S NAME: _____

STEP 6A OR STEP 6B
 VAGINAL SWABS
 PENILE SWABS

STEP 5 30 PULLED PUBIC HAIRS

STEP 4 PUBIC HAIR COMBINGS
VICTIM'S NAME: _____
DATE COLLECTED: _____ TIME: _____ am/pm
COLLECTED BY: _____
WAS SAMPLE COLLECTED? YES NO
IF NO, WHY NOT? _____

STEP 3 UNDERPANTS
VICTIM'S NAME: _____
DATE COLLECTED: _____ TIME: _____ am/pm
COLLECTED BY: _____
WAS SAMPLE COLLECTED? YES NO
IF NO, WHY NOT? _____



When is Forensic Evidence Collection Indicated?

- Sexual abuse/assault within the last 72-96 hours and there is the potential to recover biologic or trace evidence:
 - Event included vaginal, anal, or oral penetration
 - Unclear history AND there is reason to believe that there was contact with the alleged perpetrator's genitalia, blood, semen, skin cells, and saliva
 - History indicates there was a struggle that may have left some of alleged perpetrator's blood or semen on the victim's clothes or body
 - Strongly consider : digital vaginal and/or digital anal penetration or vaginal or anal penetration with an object (because digit or object could be contaminated with saliva, blood or semen)
 - History indicates that saliva could be recovered from the neck or breast or other body area

Forensic Evidence Collection *Reality* for Prepubertal Children

- Evidence is more likely to be collected from clothes or linens (Christian et. al. Forensic findings in prepubertal victims of sexual assault. Pediatrics 2000; 106:100-104).

Evidence Collection

- Collect the entire kit because sometimes disclosures are incomplete
- Collect underwear patient is wearing even if it is not the first pair
- Coordinate evidence collection with examination and STI testing to avoid multiple examinations
- Remember to assess the entire body for evidence

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STI testing prepubertal children should be performed especially under the following circumstances

- Patient has experienced penetration of the vagina, anorectum or oropharynx.
- Patient exhibits signs and/or symptoms of a STI.
- A sibling or adult in the house has a known STI.
- The perpetrator has a known STI or is at high risk.
- The perpetrator is a stranger.
- The family is requesting testing.
- Evidence of recent or old healed injury of genitals, anus, or oropharynx is present.
- Unclear history and there is reason to believe patient is at risk for acquiring a STI.
- Follow up is difficult or unlikely.

Perform STI Testing for All Teens

- Some STI testing can be obtained with urine.

STI Testing

- **HIV: send blood for HIV Antibody**
- **Hepatitis B: send blood for Hepatitis B surface antibody, Hepatitis B surface antigen, Hepatitis B core antibody**
- **Hepatitis C: Hepatitis C antibody**
- **Test for Herpes if lesions are present: send PCR from an unroofed vesicle or base of ulcerated lesion**
- **Syphilis: send syphilis Syph T (Syphilis IgG and IgM antibodies)**
- **Trichomonas: urine NAAT for trichomonas or trichomonas antigen testing if culture is unavailable**
- **N gonorrhoeae/C trachomatis:**
 - **Pharyngeal specimens: PCR**
 - **Rectal specimens: PCR if culture is unavailable**
 - **Vaginal specimens (NOT cervical): vaginal PCR OR urine PCR**
 - **Urethral specimen for males: urine PCR**
- **Genital warts: diagnosed by visual inspection**
- **If patient has vaginal or penile or rectal discharge: obtain gonorrhea culture (send E swab) and chlamydia culture (viral culture medium on ice) in addition to urine and/or rectal PCR**
- **Urinalysis and Urine Culture**
- ***although cultures have historically been considered the gold standard for child sexual abuse investigations, the recommendation for initial PCR testing is made due to concerns regarding the challenges of obtaining an adequate specimen for culture, the availability of culture media, and the difficulty in assuring that the sample is sent to the lab under appropriate environmental conditions.**

Consider STI prophylaxis (not always indicated).

- Consider the time frame in which the abuse occurred.
- In most cases, it is recommended that treatment for prepubertal children is **deferred** until testing is complete and positive test results are confirmed in a prepubertal asymptomatic child, **except for HIV**; do not delay initiation of post-exposure prophylaxis (nPEP).
- In acute cases, teens should be offered STI prophylaxis.

STI Treatment

- **Gonorrhea**

- < 45 kg : one dose of ceftriaxone 125 mg IV or IM + azithromycin 20 mg/kg PO as a single dose (max: 1,000 mg)

- > 45 kg : one dose of ceftriaxone 250 mg IV or IM+ azithromycin 1g PO as a single dose

- **Chlamydia**

- <45 kg: erythromycin base or ethylsuccinate 50 mg/kg/day (max 2g/day) PO divided into 4 doses for 14 days

- <45 kg: azithromycin, 60/mg/kg, orally in a single dose, maximum of 1 g (**data are limited on the effectiveness and optimal dose of azithromycin for the treatment of children <45 kg)

- >45 kg and <8yo: azithromycin 1 g PO single dose

- >45 kg and > 8yo: azithromycin 1 g PO single dose or doxycycline 100 mg PO BID for 7 days

- **azithromycin is not offered as a treatment option for children <45kg in Red Book due to the limited data supporting efficacy

- **Trichomonas**

- >45 kg: Metronidazole 2 g PO single dose

- <45 kg: Metronidazole 45 mg/kg per day, orally, in 3 divided doses (maximum 2 g/day) for 7 days

Perform HIV risk assessment, and offer HIV prophylaxis when indicated.

- Is it <72 hours since exposure?
- If yes, is the alleged perpetrator's HIV status known?
- **If the alleged perpetrator is known to be positive, then nPEP is recommended. If alleged perpetrator's status is unknown, then the need for nPEP is assessed on a case by case basis.**

Risk of HIV Acquisition (adapted from CDC 2016 nPEP guidelines)

Substantial Risk

- Exposure of vagina, rectum, eye, mouth, or other mucous membrane, nonintact skin, or percutaneous contact
- **With blood, semen, 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*

Negligible Risk

- Exposure of vagina, rectum, eye, mouth, or other mucous membrane, nonintact skin, or percutaneous contact
- *With urine, nasal secretions, saliva, sweat, or tears if NOT visibly contaminated with blood*
- **REGARDLESS of the known or suspected HIV status of the source**

HIV nPEP

- Perform HIV testing.
- Request that the alleged perpetrator be tested, if possible.
- Do not delay initiation of nPEP while waiting testing.
- Discuss risk of HIV acquisition with patient and caregiver.
- If additional questions, contact Pediatric Infectious Diseases (859-257-5522).

Offer emergency contraception when indicated

- Obtain pregnancy test
- Offer plan B (up to 120 hours)

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Assess Safety

- Screen for suicidal ideation and self harm
- Does the child feel safe going home?
- Does the parent feel safe going home?
- Are there concerns for substance use or abuse?

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Providing closure at the end of the ER visit

- Validate the child's feelings by acknowledging that sexual abuse disclosures are difficult to make and take courage.
- Include the child and caregiver in discharge planning by reviewing what was done during exam (exam findings, tests ordered, and what follow up care is needed). Address questions and concerns.
- **All children and adolescents need follow up to ensure that medical and emotional needs have and are being satisfactorily addressed. Investigators can and should refer the child and family to the Children's Advocacy Center in the region where they reside.**



Changing the Child Abuse System

WHAT HAPPENS TODAY WHEN KIDS NEED HELP FOR ABUSE



Robin tells her story, while a detective, CPS worker, and State's Attorney listen as a team.

Robin can see a doctor.

"This Place is Great"

Robin is referred to a counselor, who will help her heal.

Robin's mom talks to an advocate to help her understand the system.



Start Here

Robin comes to the CAC with her mom.

Tells her teacher that she is being hurt by her mom's new boyfriend at home.

... Robin talks to 3 people

When Should Follow Up Examinations Be Strongly Considered?

- Unclear exam finding that require clarification
- Uncooperative patient on initial examination
- Cases of DFSA
- Adolescent and sexually active patients
- History of genital to genital, genital to anal, and genital to oral contact
- Stranger perpetrator
- Multiple perpetrators
- Findings of trauma on previous exam (follow up ASAP unless injury has already been documented with photography) ** remember that injuries heal quickly**

Physical Symptoms that may be related to abuse

- Stress induced headaches or stomachaches
- Pain in the anogenital area
- Anogenital bleeding
- Genital discharge
- Dysuria/urinary tract infections
- Constipation/encopresis
- Enuresis
- Pregnancy

Behavior symptoms that may be associated with sexual abuse

- Difficulty sleeping
- Change in eating habits
- Change in school functioning
- Sexual acting out
- Change in interactions with family
- Anger
- Running away
- Suicidal ideation

Community Resources

- Children's Advocacy Center of the Bluegrass 859-225-5437
- CAC in your region
- UK Pediatric Forensic Medicine 859-218-6727
- UK MD's and ask for Pediatric Forensic Medicine Provider on call 859-257-5522
- UK Pediatric Infectious Disease Provider (Clinic 859-218-2533 or on Call 859-257-5522)