Recommended Guidelines
Washington State
Sexual Abuse Medical Evaluation Child 12 years and younger
2012

The following is a guideline for conducting the medical-legal examination and collecting forensic evidence for male and female children age 12 and younger when there is a report or concern of sexual abuse or assault.

For care for adolescents, see “Recommended Guidelines for Sexual Assault Medical Exam, Adult and Adolescent.”

Summary of critical changes from 2007 Guidelines:

- The time frame for forensic evidence collection for pre-pubertal children is changed from 48 to 72 hours
- The time frame for forensic evidence collection for peri- or post-menarchal children, even if under 12 years is 120 hours
- Head hair and pubic hair plucking are deleted; head hair combing deleted, pubic hair combing remains
- Recommend drying swabs with ambient air only, no fan

This document is composed of two sections, “Main” and “Details”. The “Main” section consists of a brief outline of each subject. At the end of each “Main” section is a link to the corresponding “Detail” section, in which each subject is discussed at greater depth. To review all the material about a particular issue, use the Table of Contents to locate the “Main” section, then click the link after that text to proceed to the “Detail” section.

These guidelines are not intended to include all the medical evaluations and tests that may be necessary for care for an individual patient. Likewise, not all the steps outlined here will be appropriate for every patient. The TriTech Sexual Assault Evidence Kit Re-WA 3 is designed to work with these guidelines and meets the requirements of the Washington State Patrol Crime Lab.

These guidelines were developed by a committee that included representatives from medical specialists, sexual assault nurse examiners, attorneys, forensic scientists, and law enforcement in Washington State. Development was sponsored by Harborview Center for Sexual Assault and Traumatic Stress, with support from the Washington State Department of Social and Health Services.
Recommended Guidelines
Sexual Abuse Medical Evaluation  Child 12 years and younger 2012

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PURPOSES OF THE EXAM

- **Medical:** Identify and treat injuries, diagnose other medical conditions which may be confused with sexual abuse, assess risk of sexually transmitted disease and pregnancy, document the history and medical findings. Address patient and family concerns regarding physical findings, permanent injury, and risk of disease.

- **Social/Psychological:** Respond to the patient and family’s immediate emotional needs and concerns, assess safety, explain the mandatory reporting process and Crime Victims Compensation. Provide information about typical reactions and coping strategies.

- **Forensic and legal:** Collect forensic evidence when appropriate, preserve evidence integrity and maintain chain of custody, transfer to law enforcement.

- **Refer/report:** Report to CPS and/or law enforcement authorities when there is a reasonable suspicion of child abuse, as required by law (RCW 20.44.030). Refer for follow-up medical care, advocacy, and counseling.

BACKGROUND – CHILD SEXUAL ABUSE

- The evaluation of child sexual abuse is a multidisciplinary effort. The medical evaluation, forensic interviews, forensic evidence, and investigation are all part of the evaluation.

- Sexual abuse of children is usually not physically violent. In the large majority of children the physical exam is normal. A normal or non-specific exam does not rule out sexual abuse.

- Children often report weeks or months after the abuse event.

- Physical injuries to the genital or anal regions usually heal within a few days.

- The medical provider should always consider differential diagnosis and alternative explanations for physical signs and symptoms.

- A decision to obtain a medical exam should not depend on report of “penetration”- this definition is difficult to ascertain. Children may minimize the extent of contact.

- Evidence collection
  Several recent studies concur that the chance of positive DNA findings is highest within the first 24 hours. However, positive findings for semen or saliva from body swabs can occur up to 72 hours for pre-pubertal children, and 120 hours for teens
    - When evidence is collected, collection should not be limited to those sites included in the child’s report. A child’s report may be incomplete.
A history of bathing prior to the exam does not discount the importance of DNA collection.

Clothing collection is critical when evidence is collected. Clothing, especially underwear, is the most likely positive site for evidentiary DNA.

**Scene investigation, including collection of linens and clothing should be done early.** Evidence from clothing and other objects is more likely to be positive than evidence from the patient’s body.

- It is not possible to tell from the initial evaluation what will be the outcome of any case.

**BILLING FOR THE MEDICAL EXAM**

- By law, the sexual abuse/assault exam must be billed to and paid by Washington State Crime Victims Compensation (CVC).
- A diagnosis of sexual abuse is not required for CVC coverage. The initial exam done for the purpose of documentation or gathering evidence qualifies for CVC coverage.
- The parent does not need to complete a CVC application for the initial exam. This exam is covered by CVC without application.

See Billing for the Medical Exam – Detail

**TYPES OF EXAMS**

- The type of exam will vary according to patient needs, the medical setting, and the expertise of the examiner.
- These guidelines include information suited for the acute and comprehensive exam. Providers will determine how detailed their evaluation will be in the setting where the child is seen.

**Screening exam**

- Children are often brought to an emergency department or general medical provider because of parental concern of sexual abuse.
- Includes a brief history from the adults and an exam to rule out acute injury (bruises, abrasions, lacerations) anywhere on the body, including the genital – anal area.
- If, after screening, there is low concern for child abuse, child should be referred to primary care provider for follow-up.
- If, after screening, there is reasonable concern for child abuse, then:
  - Mandatory report to authorities (CPS and/or police) should be done.
Referral should be made for:

- An acute exam for evidence collection, if within forensic time frame. 72 hours (child) or 120 hours (12 years or Tanner 3 and older).
- A comprehensive exam if outside the forensic time frame.

**Acute exam**

- Includes clarification of the history from the adults, may include history from the child. Includes a complete exam for acute injury (bruises, abrasions, lacerations), and forensic collection and labs when appropriate.
- Indicated when there has been a clear report or witnessed sexual contact within the prior 72 hours (child) or 120 hours (12 years or Tanner 3 and older).
- Additional reasons for an acute sexual assault exam, even beyond 72 or 120 hours, are:
  - Active vaginal or rectal bleeding of unknown etiology and concern for high risk situation, e.g. abduction.
  - Penetrating vaginal or anal injury without adequate history.
- If triage is on the phone, advise family
  - Do not bathe the child before exam.
  - The ED wait time and exam may be several hours.
  - Bring in clothes worn at time of incident, if possible, and bring change of clothing.
  - Come to office, clinic, or hospital with support person (family, friend, advocate).

**Comprehensive exam**

- Includes detailed history from the adults, review of prior records, conversation with child about the events when appropriate, detailed physical exam which may include colposcopy to evaluate acute and healed injuries, evaluation for STDs, and recommendations for follow-up care, including mental health and advocacy.
- This type of exam is usually done in a child abuse center by professionals who are experts in the field.
- A child may have had a screening or acute exam, and be referred for a comprehensive exam for full evaluation.
TELEPHONE TRIAGE

- When a history of contact sexual abuse is obtained, a medical exam is warranted.
- The history will guide how soon the exam should be done and whether the exam should include forensic evidence collection from the child's body.

Questions to ask:

- **What are the reasons for concern?**
  - Children often present with a combination of concerns: parent’s perception of a risky situation, non-specific physical complaints such as redness or discomfort, and child’s statements.

- **Has the child made a report of sexual contact, or was there a witness?**
  - When there is a clear history from the child, or from a witness to the abuse, a medical exam is warranted.
  - Parents may bring children in for concern of sexual abuse when the child has not made a clear statement to anyone. In these cases, further history should be obtained from the parent to clarify the concern.

- **When was the last probable contact?**
  - **72 hours** is the time frame for evidence collection for pre-pubertal children.
  - **120 hours** is the time frame for evidence collection for children 12 years or Tanner 3 and above.
  - Within these time frames, an acute exam with evidence collection should be done.

- **How old is the suspected offender?**
  - Child offenders under age 11 will not be charged with a crime. If this history is clear, then evidence should not be collected during the physical exam. If there is any concern that an older person might have been involved, then evidence collection is recommended.

- **Does the child have any physical symptoms such as pain, difficulty urinating, or blood on underpants?**
  - These symptoms and signs may indicate many different medical disorders. If there is a history or serious concern of sexual contact, the child should be seen urgently for an acute evaluation.
Refer to primary care provider when:

- Child has concerning symptoms, such as pain with urination, vaginal discharge, or signs such as vulvar redness, and no clear report or witnessed abuse.
- Visible vaginal or anal abnormality with no definite abuse event.
- A young child has made vague statements which might have a variety of interpretations.
- The primary provider may request consult with a child abuse specialist.

Refer, on a case by case basis, to primary provider or child abuse specialist:

- Children with sexual behavior problems.
- Children exposed to sexual offenders and no specific report of abuse.
- Recognize that in these cases physical findings are even more rare than in children who have reported abuse.

**LIMITED ENGLISH PROFICIENCY**

- A medical interpreter should be accessed for limited English proficiency patients.
- Family members are not appropriate interpreters in this situation.
- Professional telephonic interpreters are acceptable.
- Patients may be embarrassed to ask for an interpreter, so always assess if an interpreter is needed, even if patient/family states they do not need one.

**CONSENT FOR CARE FOR MINORS**

- In general the parent or legal guardian must consent for care for patients under 18 years of age.
- If the child is brought in by a relative or friend, the parent or guardian should be contacted to provide consent.
- If the parent or guardian is not available and the provider deems that the exam is necessary, CPS should be contacted to authorize the exam.
  - See Consent for Care for Minors - Detail
CONFIDENTIALITY

- Minors have certain rights for confidential health care in Washington state.
  - Age 13 and older may have confidential mental health care.
  - Age 14 and older may have confidential care for sexually transmitted diseases.
  - At any age may have confidential care for pregnancy or contraception.
- None of these conditions for confidentiality apply to a minor age 12 or under who may be a victim of a crime.
- Medical professionals should inform the patient that the parent or guardian will be told what the patient reported.
- Medical professionals should inform the parent or guardian about the sexual abuse/assault event or concern.
- If the parent or guardian is not protective, CPS should be informed.

MANDATORY REPORTING

- A report is required when there is reasonable suspicion by the medical provider that a child has been sexually or physically abused RCW 26.44.030.
- Report must be made to CPS, police, or both. In Washington state, CPS and police share information regarding child abuse reports.
  - CPS must be informed if there is suspicion that a caregiver or parent may have abused a child, or if there is concern about safety in the home.
  - Police should be informed as soon as possible if forensic evidence is collected.
- Parental consent is not required. Information to parents about the report is not required but is good clinical practice.
- Sexual exploration or play between similar-age peers without force or coercion is not a crime and does not require a CPS report. However, a report should be made if there is concern of caregiver neglect.

See Mandatory reporting – Detail
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

- Medical information, records, and forensic evidence regarding possible child abuse must be released to the investigating agency.
- HIPAA privacy regulations are over-ridden by child protection requirements [RCW 26.44.040].
  - See Authorization for release of protected health information – Detail

MALE VICTIMS

- Boys can be victims of sexual assault by women or by men.
- Sexual assault evidence should be collected as for females, with only a few differences in collection details.
- Special issues for boys assaulted by adult or teen males include a higher risk of STDs, including syphilis and HIV.
- HIV post-exposure prophylaxis should be considered for male victims of male assailants when there has been penile-anal penetration.
  - Infectious disease specialists should be contacted immediately. Some of the drugs recommended for HIV PEP in adults are not approved for children.
- See HIV risk assessment and post exposure prophylaxis – Detail

ADVOCACY AND SUPPORT

- Many hospitals have a partnership with the local Community Sexual Assault Advocacy Program (CSAP).
- If this partnership is not in place, provide information regarding local Community Sexual Assault Advocacy Programs before discharge.

MEDICAL HISTORY FROM THE PARENT, GUARDIAN, OR LAW ENFORCEMENT

- History is obtained from the parent, guardian, and/or law enforcement. This information may be obtained by the health care provider or a designated member of the team.
- Provide privacy for initial history from parent or guardian.
- Obtain and document information regarding the assault event in order to provide appropriate medical care and evidence collection.
- Identify sources of information.
- History of the current event and concerns should be obtained, when possible, outside the hearing of the child if the child is 3 years or older. Overhearing another’s account may change a child’s report.
- Past medical history and review of systems are obtained as for all patients.
- Social history must include the people in the child’s household, and information about other children who may be at risk for abuse or assault.
- See Medical history from the parent or guardian – Detail

**MEDICAL HISTORY FROM THE CHILD**

- The medical history is for the purpose of medical diagnosis and treatment and psychosocial assessment, and does not substitute for a forensic interview.
- Obtaining the medical history does not require special training, but the professional should adhere to basic rules of non-leading and open-ended questioning and should know the advantages of encouraging free narrative.
- It is preferred that the child to talk to the medical provider with the parent or other emotionally involved persons out of the room.
- Document who was present during the conversation with the child.
- Document questions asked and child’s answers “near verbatim.” Documents words used by medical provider and child’s own words.
  - See Medical history from the child - Detail

**MEDICAL EXAM TECHNIQUES FOR CHILDREN**

- Every child should have a complete head to toe exam with attention to signs of trauma.
- The exam should never be painful. The exam should be done in a manner that is least disturbing to the child.
- The order of exam and evidence collection can vary, it is usually best to begin with less sensitive areas (hands, face).
- Explain to parent or support person that their job is to talk to and distract the child. The findings of the exam will be discussed with them after the exam is completed.
- Injury findings (bruises, abrasions, lacerations) should be noted in writing as well as photo-documented. Use of a bodygram (traumagram) is helpful.
- If there is no clear indication for forensic evidence collection, the exam can often be deferred to another outpatient setting.
If the child resists the exam

- If a child of any age refuses the genital-anal exam, it is a clinical judgment of how to proceed. A rule of thumb is that the physical exam should not be more traumatic than the sexual abuse. It may be wise to defer the exam under these circumstances.

- The child should not be held down or restrained for the exam; it is not possible to do an adequate exam under these conditions (exception for infants or very young toddlers).

- Sedation is rarely needed if the child is informed about what will happen and there is adequate parental support for the child.

Girls

- Genital exam is done in the supine frog leg or in the dorsal lithotomy position.

- Use both labial separation and labial traction.

- Perineal and anal exam is done in the supine knee-chest (cannonball) position.

Boys

- Genital exam is done with the patient sitting, lying, or standing.

- Perineal and anal exam is done in the supine knee-chest (cannonball) position.

See Medical exam techniques for children – Detail
FORENSIC EVIDENCE COLLECTION

- If the child’s statement (or statement of witnesses) is specific or highly concerning for sexual contact, and the reported contact was within the forensic timeframe, evidence collection is indicated.
  - Evidence should be collected even when a child has bathed after the contact.
  - Evidence should not be collected if the “offender” was under 11 years of age.

- Tri–Tech Forensics kit RE-WA3 was developed to conform to these guidelines, and meets the requirements of the Washington State Crime Lab. This kit can be ordered from [http://www.tritechforensics.com](http://www.tritechforensics.com).

- In the RE-WA3 kit each label and envelope has specific instructions on how each specimen should be collected.

- In general, when the decision is made to collect evidence the entire “Sexual Assault Evidence Kit” should be collected because:
  - The child may not recall or may not be willing to say everything that happened.
  - Approaching evidence collection in a uniform manner decreases missed areas and errors.

- If the child adamantly refuses to allow evidence collection, it may be possible to bargain with the child. Many children will allow examination and swabs of the head, neck, chest and abdomen. Underpants can be collected (especially if new underpants are provided). This is a reasonable compromise under some circumstances.

- The order of the exam and evidence collection can vary. It is usually best to begin with less sensitive areas (hands, face).

- Use gloves, change frequently during evidence collection.

- Recognize that clothing and household linens may be the best source for DNA evidence. If needed, inform police to collect evidence from scene.

See Forensic evidence collection – Detail
See Forensic evidence collection – Table
EVIDENCE PACKAGING, STORAGE, AND TRANSFER

- Details of evidence packaging may be obtained from “Sexual Assault Evidence Packaging Handbook” for Washington State, available online.

Clothing, underpants and diapers
- Each item of clothing worn at the time of the assault should be placed in a separate paper bag, taped closed, and labeled.
- Dry underpants should be placed in paper bag and sealed in kit.

Wet items
- If items cannot be dried (e.g., diapers, wet underpants or clothing), package in either in biohazard bag OR double paper (may put plastic biohazard bag on the bottom of the paper bag) and transfer to police within 3 hours. If a locked freezer is available wet evidence may be frozen until transfer. Mark the outside of these packages “WET” so police evidence management will know to dry the items.

Chain of custody of evidence
- One staff member must be responsible for maintaining chain of evidence. That staff member at all times:
  - Maintains continuous physical possession of specimens and items of evidence OR
  - Designates another staff member to maintain possession of evidence OR
  - Locks specimens in closed area (room, cabinet, refrigerator or freezer).

Swab specimens
- Place in a pre-labeled drying rack.
- Skin swabs, Label swabs “Site 1”, “Site 2” etc. On the kit envelope for skin swabs indicate sites of skin swabs. If known, specify on the envelope “semen” or “saliva”, if known.

Drying swabs
- Maintain chain of custody while drying.
- Swabs may be locked in room, cabinet or drying box to dry.
- Do not use heat or fan to dry swabs.
- If plexiglass drying box is used:
  - Place swabs from only one patient at a time in drying box.
- Use plastic “Crash cart” lock to close box or lock box in a cabinet or room.
- When drying is complete, place used plastic lock into evidence kit to demonstrate chain of custody of evidence.
- Clean drying box between uses with hospital approved disinfectant or 20% bleach.

**Time for drying**
- A swab moistened with 3 drops of water will take 1 hour to dry in a standard drying box. Swabs left outside of a box will take a similar time to dry.

**What happens to evidence**
- Forensic specimens are not processed within the hospital, but stored separately and transferred to law enforcement.
- Evidence may be tested by the Washington State Patrol Crime Lab but all evidence is not necessarily processed.
- Medical providers will not be informed of the forensic evidence findings.

**MEDICAL PHOTOGRAPHY**
- If visible injuries on the body or genital area, document by hand drawing (on a bodygram or traumagram) in addition to photographing. Remember photos can be lost or impaired by technical error.
- Patient must be identified in photos – make the first photo of the patient hospital ID label, and the second of the patient’s face.
- Photos of body injuries should be taken 3 times: first, from 3 feet away, then close-up, then close up with a measuring device.
- Photos of genital-anal injuries do not require use of a measuring device or a 3 foot away photo.
- A standard protocol should be in place for taking photos, storage, and transfer.
- See Medical photography - Detail
LAB TESTS

Pregnancy test
- Obtain urine pregnancy test on all females ages 10 years (or Tanner stage 3) and above. Blood test is not more sensitive. Girls can be pregnant before their first known menstrual period.

STD tests
- Testing is recommended if there is:
  - Vaginal discharge OR
  - Report of penile-vaginal contact, penile-oral, or penile-anal contact by a teen or adult male.
- Vaginal discharge in a pre-pubertal girl
  - May be due to non-specific irritation, strep or other respiratory pathogens, enteric pathogens, or chlamydia or gonorrhea.
  - Swab posterior fourchette for routine bacterial culture (usually specify “vulvar culture” and gonorrhea. Use NAAT for chlamydia test.
- History of penile-vaginal contact by adult or teen male
  - Urine nuclear amplification (NAAT) for gonorrhea and chlamydia
  - Positive NAATs must be confirmed by a different NAAT or conventional culture.
  - Consider HIV serology, and HIV post exposure prophylaxis if within 72 hours and risk factors (see below).
- History of penile-oral contact by adult or teen male
  - Gonorrhea culture of pharynx.
  - Chlamydia and gonorrhea NAAT is not approved for this site unless the lab has done internal validation of the method by a verification study.
  - Chlamydia culture is not recommended for this site.
- History of penile-anal contact by adult or teen male
  - Gonorrhea culture of anus.
  - Chlamydia and gonorrhea NAAT is not approved for this site unless the lab has done internal validation of the method by a verification study.
  - If chlamydia culture available, may be used at this site.
  - Consider HIV serology, and HIV post exposure prophylaxis if within 72 hours.
  - See Sexually transmitted diseases in children - Detail
HIV Testing

- The decision to recommend HIV testing depends on local epidemiology, and a case by case assessment of risk factors of the assailant and details of contact.
- Testing should be done at baseline, 2, 6, 12 and 24 weeks after the sexual contact.

MEDICAL TREATMENT

Emergency contraception

- Levonorgestrel (Plan B One-Step or Next Choice) is most effective if taken early, but has efficacy up to 120 hours after unprotected intercourse.
- Discuss and provide emergency contraception when:
  - Patient is Tanner Stage 3 or above, even if premenarchal AND
  - There is a reasonable concern for semen – vaginal contact (even if a condom was used) AND
  - Sexual contact occurred within prior 120 hours AND
  - Patient feels any pregnancy conceived in the last five days would be undesirable to continue AND
  - Pregnancy test is negative.
- If patient has not had a previous menstrual period, advise that there may be vaginal bleeding within a few days.
- In Washington the patient or any age has the right to confidential care for reproductive health, in practical terms patients under 12 years may not have the cognitive ability to provide informed consent. In these cases the parent or guardian must be informed and assist in decision making.
  - See Medical treatment - Detail

Gonorrhea and Chlamydia Prophylaxis

- Children should not be treated for gonorrhea or chlamydia before confirmatory tests are performed.
  - See Sexually transmitted diseases in children - Detail
HIV Post-exposure Prophylaxis

- May be indicated when
  - Sexual contact was within prior 72 hours AND
  - There was probable semen to mucosa contact.
  
  AND any one of the following:
  - Contact was by a man at high risk (esp. man who has sex with men) OR
  - There was more than one offender OR
  - There was penile anal penetration OR
  - The victim has grossly identifiable genital or anal injury skin disruption.
  - Family has a high concern for HIV infection, after discussion of low relative risk.

- If HIV PEP is recommended, consult promptly with a specialist in pediatric infectious disease.

See HIV risk assessment and post exposure prophylaxis – Detail

DISCHARGE

- Explain physical findings.
- Explain follow-up for medical test results (who will contact the family).
- Discuss CPS report.
- Explain that if police report was made, detective will contact patient within several days.
- Provide written discharge instructions.
- Provide written information regarding local sexual assault advocacy organizations and other crisis services.

See WCSAP Find Help in your Community
FOLLOW-UP MEDICAL CARE

- Follow-up medical visit by primary care or specialized medical provider is recommended in 1-3 weeks after the acute exam.
- Review current physical and psychological symptoms.
- Review lab work done at acute exam, recommendations for further lab tests.
- Review family stresses and functioning.
- Provide physical exam to evaluate healing of injuries or any symptoms, if appropriate.
- Refer for legal and/or counseling support.

See Follow-Up Medical Care - Detail
BILLING FOR THE MEDICAL EXAM – DETAIL

- The initial medical forensic exam for sexual assault for the purpose of gathering evidence for possible prosecution must be billed only to Washington State Crime Victims Compensation.
- Billing requires the use of specific local codes and completion of a CVC billing form.
- The patient is not required to make a police report for CVC to pay the charges for the exam.
- There does not need to be a “positive finding” of sexual assault for the exam to be covered by CVC.
- CVC information should be given to the parent or guardian.
- An application to CVC should not be submitted for the ED visit, which is already covered without an application to CVC.
- For further information see Washington State Crime Victim’s Compensation.
CONSENT FOR CARE FOR MINORS- DETAIL

- In general, the parent or legal guardian must consent for care for patients under 18 years of age.
- If the child is brought in by a relative or friend, the parent or guardian should be contacted to provide consent.
- If the child’s parent or legal guardian is unavailable or unwilling to sign consent for care, and the medical providers deem that an exam for sexual abuse must be done emergently, the following steps should occur:
  - Medical provider confers with CPS regarding circumstances.
  - CPS notifies police to take the child into protective custody.
  - Police take the child into emergency protective custody.
  - CPS authorizes medical exam.
  - CPS arranges placement.
- If the patient feels it would be unsafe to tell the parent or guardian, then Child Protective Services should be contacted to assess safety and provide consent for care.

[back to Consent for care for minors- Main]
MANDATORY REPORTING – DETAIL

- A report is required when there is reasonable suspicion by the medical provider that a child has been sexually or physically abused RCW 26.44.030.

- Health care workers and other mandated reporters must report when they have reasonable cause to believe that a child (person under 18 years of age) has experienced sexual abuse, assault, or sexual exploitation by any person, including non-caregivers.

- The report must be made to law enforcement or Child Protective Services at the first opportunity, in no case longer than 48 hours. In Washington state, CPS and police share information regarding child abuse reports.
  - CPS must be informed if there is suspicion that a caregiver or parent may have abused a child, or if there is concern about safety in the home.
  - Police should be informed as soon as possible if forensic evidence is collected.


- Report to law enforcement in the jurisdiction where the suspected abuse occurred.

- If the jurisdiction is not known, call 911, state “This is not an emergency” and ask for assistance in determining the jurisdiction of the address where the suspected abuse occurred.

- Because the concern is regarding a criminal event, parents or guardians should be informed about the report.

- Sexual exploration or play between similarly aged peers without force or coercion is not a crime and does not require a CPS report.

- In Washington State, sexual contact without force is a crime if there is a specific age difference between the participants. The older person may be charged with rape of a child or child molestation.

<table>
<thead>
<tr>
<th>Age of younger child</th>
<th>Age of older child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 12</td>
<td>24 months or more months older</td>
</tr>
<tr>
<td>12 or 13 years</td>
<td>36 months or more older</td>
</tr>
<tr>
<td>14 or 15 years</td>
<td>48 months or more older</td>
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</table>

- If any force coercion is involved, the age difference is irrelevant, and the contact is illegal whatever the age difference.

[back to Mandatory reporting -Main]
Authorization for release of protected health information

- Information, medical records, photographs obtained by medical personnel, and evidence including clothing and forensic evidence are protected health information.

- Sharing information: Upon receiving a report, DSHS and law enforcement shall have access to all relevant records of the child in the possession of mandated reporters and their employees (RCW 26.44.030).

- Medical information, records, and forensic evidence regarding possible child abuse must be released to the investigating agency.

- State child abuse regulations pre-empt HIPAA regulations.

- Parental consent is not required for release of protected health information to CPS and/or law enforcement.

- See RCW 26.44.040
Medical history from the parent or guardian – Detail

- Obtain history from the parent, guardian, and/or law enforcement. This information may be obtained by the health care provider or a designated member of the team.
- Obtain and document information regarding the assault event in order to provide appropriate medical care and evidence collection.

**Document**
- Person(s) who accompanied patient and relationship to patient.
- Sources of information
- Police report if filed: police department and case number
- Who was present when history of the event was obtained
  - When possible, it is strongly recommended that a child who is over age 3 should not over hear this information as it may influence a child’s statements later.

**Medical History**
- Brief narrative history of concern or report of abuse.
- Time and place of abuse.
- Time since event or suspected event.
- Physical symptoms or signs noted by parent or guardian: itching, bleeding, discharge, constipation, diarrhea.
- Behavioral changes such as anxiety, sleep disturbance, toileting problems.
- What specific contact occurred, as far as the parent knows:
  - Oral, vaginal or vulvar, anal contact.
  - Saliva or semen contact to skin, where.
  - If a condom was used.
- Events since suspected abuse. If patient has:
  - Showered, bathed, cleaned genital-anal area, rinsed mouth, eaten, drank, urinated or defecated since the alleged abuse.
  - Changed clothes, gave clothes to police at scene, or brought clothes worn at time of assault to medical setting.
- Action the parent or guardian took, CPS or police report, communication with reported offender, statements to their child.

[cont’]
PAST MEDICAL HISTORY
- Developmental status, including communication delays, learning disabilities, special education.
- Age at menarche, or if premenarchal.
- Active and significant past medical problems.
- History of genital surgery, including urinary catheterizations.
- Current and recent medications, including antibiotics.
- Allergies to medications

REVIEW OF SYSTEMS
- Special attention to GU or possible trauma related symptoms: vaginal or rectal discomfort, dysuria, vaginal or rectal discharge or bleeding, or bruising.
- Emotional symptoms: depression, anxiety, or behavior problems.

SOCIAL HISTORY
- Household composition: who lives in home.
- Other caregivers for child.
- Other children who may be at risk.
- NOTE: Caution should be exercised when documenting parent’s personal history for reasons of confidentiality.

[back to Medical history from the parent, guardian, or law enforcement - Main]
MEDICAL HISTORY FROM THE CHILD - DETAIL

- The medical history is for the purpose of medical diagnosis and treatment and psychosocial assessment, and does not substitute for a forensic interview.
- Obtaining the medical history does not require special training, but the professional should adhere to basic rules of non-leading and open-ended questioning and should know the advantages of encouraging free narrative.
- It is preferred that the child to talk to the medical provider with the parent or other emotionally involved persons out of the room.
- Document
  - Persons present during conversation with child
  - Demeanor of child
  - Near-verbatim of questions asked and child’s answers (not paraphrase)
- Help to put the child at ease by initiating neutral conversation.
- Use this conversation to do a developmental assessment of the child’s speech. Is the child able to give a free narrative of a neutral or positive event? (What happened at school today? What happened at your last birthday?)
- Ask non-leading questions (“Why did your parent bring you here today?” or “Is there a problem?”, or “Has someone been bothering you?”)
- Allow child to fully answer each question before asking another.
- Encourage free narrative.
  - Understand that free narrative will give the most accurate report.
  - Yes or no questions may result in more but less accurate information.
- Avoid yes or no questions and multiple choice questions.
- Do not introduce new information, such as actions (“did he do …?”) in questions. Referring to prior statements by the child is acceptable (“you told me he did …”)
- It is not necessary for the medical provider to obtain all the details of the event.
- If a child is reluctant to speak, and answers only “yes” or “no” or “I don’t know” it may be best practice to discontinue efforts to obtain the history at that time.

*If the child is unwilling or unable to provide the history, do not persist.*

[Back to Medical history from the child - Main]
MEDICAL EXAM TECHNIQUES FOR CHILDREN – DETAIL

GENERAL
- The exam should never be painful. The exam should be done in a manner that is least disturbing to the child.
- The order of exam and evidence collection can vary, it is usually best to begin with less sensitive areas (hands, face).
- Explain to parent or support person that their job is to talk to and distract the child. The findings of the exam will be discussed with them after the exam is completed.
- Injury findings (bruises, abrasions, lacerations) should be noted in writing as well as photo-documented. Use of a Bodygram (Traumagram) is helpful.
- If there is no clear indication for forensic evidence collection, the exam can often be deferred to another outpatient setting.

IF THE CHILD RESISTS THE EXAM
- If a child of any age refuses the genital-anal exam, it is a clinical judgment of how to proceed. A rule of thumb is that the physical exam should not be more traumatic than the sexual abuse. It may be wise to defer the exam under these circumstances (see below for Forensic Evidence Collection.
- The child should not be held down or restrained for the exam, it is not possible to do an adequate exam under these conditions (exception for infants or very young toddlers).

TECHNIQUES TO HELP THE CHILD RELAX
- Offer clear age-appropriate explanations for the reasons for each procedure, offer patient some control over the exam process.
- Proceed slowly, explain each step in advance.
- Use drapes to protect privacy, if the child wishes.
- Explain to parent or support person that their job is to talk to and distract the child, and the findings of the exam will be discussed with them after the exam is completed.
- Position the parent near the child’s head.
- Use distractors. For example
  - Ask the parent to sing a song, or tell a familiar story, or read a book to the child. A nurse or other provider can do this if the parent is unable.
  - Use a Viewmaster, TV, bubbles, cellphone game, or other visual distraction.
- Do not forcibly restrain the child for the exam
[cont’]
IF THE CHILD CANNOT COOPERATE WITH THE EXAM

- In cases where the child refuses the physical exam, the following evaluation should occur.

Assess:

Is the parent’s concern exacerbating the child’s anxiety?
- If so, the medical provider should take the parent aside and listen to their concerns. If necessary, and if the parent is in agreement, the parent should remain outside the room during the exam.

Is the child non-specifically distressed?
- Offer conversation, reassurance, food, distraction.

Is forensic collection needed right now?
- Clothing, especially underpants, are the most important source of DNA.
- Underpants and other clothing worn at the time of suspected abuse / assault should be collected and packaged as evidence.
- A child who is unable to allow genital examination may be happy to trade their underpants for a new pair.

Can the genital exam be deferred?
- Genital injury is uncommon in child sexual abuse. In the absence of genital bleeding or pain, the likelihood of injury is relatively low.
- Active genital or anal bleeding is a clear indication that the exam should be conducted urgently.

SEDATION

- Sedation is rarely needed if the child is informed about what will happen and there is adequate parental support for the child.
- Conscious sedation is an option if examination and evidence collection is required, and the child is not able to cooperate.
- Speculum exam on a prepubertal girl should be done under anesthesia, not conscious sedation.

[cont’]
GENITAL EXAM TECHNIQUES

- Requirements for the exam are
  - A reasonably relaxed patient
  - A good light source
  - A stool for the examiner
- Usually the exam is easiest if the child removes their underpants or diaper (with parent’s help) and is draped for privacy. Some younger children do not like to be draped.
- For a very anxious child (boy or girl), exam can be done with the underpants on. For girls in the supine frog-leg position, underpants can be moved to the side for the vulvar exam, and pulled down for the perineal and anal exam.

GIRES

Examination positions and techniques are:

- Frog leg, supine OR
- Dorsolothotomy (stirrups, for older children) OR
- Modified frog leg, on the parent’s lap. Parent may sit or lie back on the exam table.
  - Examine the labia minora and inner thighs without touching the patient.
  - Labial separation (separating the labia majora laterally).
  - Labial traction (gently grasping the labia majora and pulling slightly towards the seated examiner. This allows much better visualization of the introitus.
  - Gentle water irrigation may be used by advanced examiners to visualize folds in the hymen.
  - Prone knee chest position may be used by advanced examiners as adjunctive technique
- Supine knee-chest (child on her back hugging her knees)
  - To examine the perineum and anus.
  - Separate anal folds, note presence or absence of acute lacerations.
  - Venous engorgement may mimic bruising, have the patient sit up and then lay down again to determine which is present.

(cont’
**Boys**

For boys, examination positions are:

- Supine, sitting or standing
  - Examine all sides of the penis and scrotum.
- Supine knee chest (cannonball, with child hugging his knees)
  - Perineum
  - Anal exam: Separate anal folds, note presence or absence of acute lacerations.
- Venous engorgement may mimic bruising, have the patient sit up and then lay down again to determine which is present
FORENSIC EVIDENCE COLLECTION – DETAIL

GENERAL

- For children, it is often easiest to do the complete medical exam, then photographs, then forensic evidence collection.
- The order of exam and evidence collection can vary. It is usually best to begin with less sensitive areas (hands, face).
- Injury signs (bruises, abrasions, lacerations) should be noted in writing as well as photo-documented.
- In general, use all steps of the evidence collection kit
  - Because a patient may not recall or may be embarrassed to report all aspects of the assault, the exam should be complete and evidence collection from all orifices (mouth, vagina, rectum) is routine.
- Use powder free gloves, and change frequently during exam to minimize cross-contamination.
- Affix labels to the drying rack in advance to indicate site of swabs.
- For orifice swabs, use 4 swabs for each site.
- For skin swabs, use 2 swabs for each site, use “wet-dry” swab technique as this increases recovery of foreign DNA.
  - Moisten one swab with sterile water (supplied in kit). Swab area lightly.
  - Repeat with dry swab.
  - Label swabs and diagram on envelope to indicate sites (SS #1, SS#2, etc)
- Write on envelope any variations or modifications used in collecting evidence.

[back to Forensic evidence collection -Main]
## Forensic Evidence Collection – Table

Specific instructions for evidence collection are printed on each envelope of the Washington State Evidence Kit (Tri-Tech USA).

<table>
<thead>
<tr>
<th>Exam</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urine pregnancy test</strong></td>
<td>For all females who are post-menarchal, Tanner 3 or above, or over 10 years of age. Urine collection for pregnancy test (this is as sensitive as current blood tests)</td>
</tr>
<tr>
<td><strong>Toxicology</strong></td>
<td>If patient appears impaired, or history of alcohol ingestion within prior 12 hours. Obtain stat blood alcohol and urine toxicology through hospital lab</td>
</tr>
<tr>
<td><strong>Forensic toxicology</strong></td>
<td>Routine. If abuse was within prior 24 hours, collect urine and blood for forensic toxicology. Urine for forensic toxicology (routine). If &lt; 24 hours, 2 grey-top blood tubes + 30 ml urine. If &gt;24 hours, 30 ml urine only. Collect urine in standard specimen cup, then transfer urine to state toxicology leakproof plastic cup or 2 red top tubes. Place in biohazard bag. Maintain at room temperature refrigerate (urine only) or freeze until transfer. Do NOT freeze glass tubes. Do NOT package in kit. Transfer separately to law enforcement.</td>
</tr>
<tr>
<td><strong>Mouth</strong></td>
<td>Examine soft and hard palate, inner lips and tongue for bruising or lacerations. Note missing teeth. Oral swabs. Use 4 cotton swabs total. Do not moisten. Using 1 swab at a time, swab around gingival border, at margins of teeth, buccal and lingual surfaces. Repeat with remaining 3 swabs.</td>
</tr>
</tbody>
</table>
| **Hands** | **Examine for nails broken at assault, wounds on hands**  
**Examine for foreign debris** | **Fingertip swabs**  
Use 4 swabs total - 2 swabs for each hand  
With 1 moistened swab, swab all 5 fingertips of one hand, concentrating on area under nails  
Repeat with 1 dry swab on same hand  
Repeat process on other hand  
Both swabs from one hand may be packaged in same box |
| --- | --- | --- |
| **Blood specimen on filter paper** | **To obtain patient DNA**  
**Do not obtain for young children unless drawing blood for other tests** | **Blood reference sample**  
Use lancet from kit, or small needle and syringe  
May obtain at the same time in same syringe as other labs  
Place blood on designated filter (FTA) paper, fill at least 2 circles  
(This step may be more traumatic for young children than any other part of the evaluation. DNA reference sample can be obtained later) |
| **Trace Debris** | **If patient has not bathed or changed clothes, especially when assault was out of doors** | **Trace debris**  
Place clean cloth or paper sheet on floor  
Place paper from “Trace Debris” envelope on top  
Have patient undress while standing on paper  
Fold paper to retain debris  
Place in envelope, seal, sign and date over tape  
Have patient dress in examination gown |
| **Clothing** | **Examine clothing for rips, stains. Ask if these occurred during abuse/assault. Document on report** | **Collect clothing worn at time of abuse/assault**  
Place each article in a separate brown paper bag  
Tape, label bags |
| Underpants | Collect underpants, even if changed after assault  
| Diapers | Package in a small paper bag  
| | Seal, label, place in the Evidence Kit  
| | Note: Do not attempt to dry wet underpants or diapers. Either transfer to law enforcement within 3 hours, or place in double paper bag, seal, place in open plastic container (basin) or open plastic bag. Label “WET” and refrigerate or freeze until transfer  
| Head and neck | Scalp: Palpate for tenderness or swelling  
| | Ears: blood in canals, bruising on pinna or behind ear  
| | Neck: tenderness or limitation of motion  
| | Eyes: Conjunctival hemorrhage, sclera and inner eyelids) Periorbital petechiae  
| | Skin swabs  
| | Ask patient if areas may have assailant saliva or semen deposition  
| | Swab all suspect areas, as well as visible bite marks or suction bruises, and dried secretions on skin  
| Skin | Skin swabs  
| Chest/ Breasts | Swab areas where patient reports saliva or ejaculation, or where dried secretions are seen  
| Abdomen | Obtain swabs even if patient bathed after event, since bathing may be incomplete  
| Extremities | Use 2 swabs total for each site  
| | Moisten 1 swab with 1 drop of water  
| | Swab area of suspected foreign secretions  
| | Repeat with second, dry swab  
| | Repeat 2 swab wet/dry technique for each suspect area  
| | Indicate on envelope if saliva or semen is suspected by patient report
<table>
<thead>
<tr>
<th>Genital exam female</th>
<th>Pubic hair combing if patient has pubic hair</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examine in frog leg or dorsal lithotomy</td>
<td>With patient in dorsal lithotomy, place clean paper under buttocks</td>
</tr>
<tr>
<td>Examine inner thighs, labia majora, perineum</td>
<td>Using supplied comb, comb downward to collect loose hairs</td>
</tr>
<tr>
<td>Document tenderness, bruises, abrasions, lacerations, Examine vulva and perineum</td>
<td>Fold paper to retain hairs, and place in envelope</td>
</tr>
<tr>
<td>Speculum exam is rarely needed for premenarchal girls if needed for active bleeding or foreign body, must be done under general anesthesia</td>
<td>If a possible foreign pubic hair is found, collect with cotton swab, place in “Pubic hair combing” paper and envelope, and label explicitly where hair was found</td>
</tr>
<tr>
<td>Vulvar/perineal swabs</td>
<td>If matted pubic hair is noted, use clean scissors to clip hair</td>
</tr>
<tr>
<td>Examine inner labia and vaginal introitus (hymen)</td>
<td>Vulvar/perineal swabs</td>
</tr>
<tr>
<td>Using labial separation and then labial traction, examine labia majora, labia minora, introitus, posterior fourchette, fossa navicularis</td>
<td>Use 4 cotton swabs total</td>
</tr>
<tr>
<td>Vaginal swabs</td>
<td>Moisten 2 swabs with 1 drop of water on each</td>
</tr>
<tr>
<td>Use 4 cotton swabs total</td>
<td>Swab external genital folds and perineum</td>
</tr>
<tr>
<td>Using two moistened swabs at a time, swab inner labia bilaterally, avoid contact with labia majora and hymen</td>
<td>Repeat with 2 dry swabs</td>
</tr>
<tr>
<td>Package in “vaginal swabs” envelope, specify site of collection in chart and on envelope</td>
<td>Retained foreign bodies</td>
</tr>
<tr>
<td>Place in urine specimen cup</td>
<td>Place in urine specimen cup</td>
</tr>
<tr>
<td>Place cup in biohazard bag and label</td>
<td>Place cup in biohazard bag and label</td>
</tr>
<tr>
<td>Transfer to law enforcement within 3 hours or freeze for later transfer</td>
<td>Transfer to law enforcement within 3 hours or freeze for later transfer</td>
</tr>
<tr>
<td>Toluidine blue dye</td>
<td>Toluidine blue dye</td>
</tr>
<tr>
<td>Not indicated for children or young teens</td>
<td>Not indicated for children or young teens</td>
</tr>
<tr>
<td>Bimanual exam</td>
<td>Bimanual exam</td>
</tr>
<tr>
<td>Not indicated for children or young teens</td>
<td>Not indicated for children or young teens</td>
</tr>
<tr>
<td>Genital exam – Male</td>
<td>Penile swabs</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Examine inner thighs, all sides of penile shaft, corona, foreskin, glans penis, scrotum, and perineum</td>
<td></td>
</tr>
<tr>
<td>Document abrasions, bruises, lacerations, erythema, and inflammation</td>
<td></td>
</tr>
<tr>
<td>Penile swabs</td>
<td></td>
</tr>
<tr>
<td>Use 4 cotton swabs. Moisten 2 with 1 drop of water on each</td>
<td></td>
</tr>
<tr>
<td>Swab penis: anterior, lateral, posterior and glans penis and under foreskin with moistened swabs</td>
<td></td>
</tr>
<tr>
<td>Repeat with 2 dry swabs</td>
<td></td>
</tr>
<tr>
<td>After drying, package in “vaginal endocervical” envelope. Write “Penile swabs” on envelope</td>
<td></td>
</tr>
<tr>
<td>Perineal swabs</td>
<td></td>
</tr>
<tr>
<td>Use 4 cotton swabs total</td>
<td></td>
</tr>
<tr>
<td>Moisten 2 swabs with 1 drop of water on each</td>
<td></td>
</tr>
<tr>
<td>Swab perineum and scrotum</td>
<td></td>
</tr>
<tr>
<td>Repeat with 2 dry swabs</td>
<td></td>
</tr>
<tr>
<td>After drying, package in “Vulvar-perineal” envelope and write on envelope “Scrotum/perineum”</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anal exam, male and female</th>
<th>Perianal swabs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document perianal abrasions, lacerations, bruising</td>
<td></td>
</tr>
<tr>
<td>For girls, exam may be done in dorsal lithotomy position or supine knee chest</td>
<td></td>
</tr>
<tr>
<td>For boys, examine in supine knee-chest</td>
<td></td>
</tr>
<tr>
<td>Separate anal folds to visualize lacerations</td>
<td></td>
</tr>
<tr>
<td>Digital exam is not indicated, except if concern for foreign body retention</td>
<td></td>
</tr>
<tr>
<td>Perianal swabs</td>
<td></td>
</tr>
<tr>
<td>Use 2 swabs total</td>
<td></td>
</tr>
<tr>
<td>Moisten 1 swab with 1 drop water</td>
<td></td>
</tr>
<tr>
<td>Swab peri-anal folds. Repeat with dry swab</td>
<td></td>
</tr>
<tr>
<td>Anal swabs</td>
<td></td>
</tr>
<tr>
<td>Use 2 swabs total</td>
<td></td>
</tr>
<tr>
<td>Moisten each with 1 drop of water</td>
<td></td>
</tr>
<tr>
<td>Insert 1 swab 1-2 cm into anus</td>
<td></td>
</tr>
<tr>
<td>Repeat with second moistened swab</td>
<td></td>
</tr>
</tbody>
</table>

[back to Forensic evidence collection - Main]
**MEDICAL PHOTOGRAPHY - DETAIL**

- If visible injuries are present, photography with digital or video camera.
- Video should have no sound recording unless all parties are aware of and consent.
- Careful documentation with drawing or writing is mandatory even when photographs are obtained.
- Always document name of photographer and date of photos. This may be done by documentation in the chart, in a photo log, or by writing the photographer name and date on the patient identification label which is then photographed.
- Staff must be trained in specific camera and photography techniques.
- If date function is used, verify that date is correct.
- Check flash function: photos may be better either with or without flash.

**TECHNIQUE**

- First photo is of patient identification label.
- Second photo patient’s face.
- Photograph each injury site 3 times.
  - First, at least 3 feet away, to show the injury in context
  - Second, close up
  - Third, close up with a measuring device (ruler, coin, or ABFO rule)

**BODY PHOTOS**

- Photos of body injury may be more significant than genital injury in sexual assault cases.
- Drape patient appropriately, photos may be shown in open court.

**BITE MARKS**

- Bite marks should be photographed, but police should be notified for police photographer to obtain technically optimal photos.
- Use of a measuring device and good technique (camera perpendicular to plane of skin) is particularly important.

**COLPOSCOPY PHOTOS OF GENITAL OR ANAL INJURY**

- Magnified photos of the genital or anal area can document injury.
- Use photo or video-colposcope, or camera with macro function.
- Measuring device is not needed in these photos.
- If blood or debris is present, photograph first, then clean area and photograph again.
PHOTO STORAGE AND RELEASE

- Provide formal tracking of copies, release dates, and person responsible for releasing and receiving photos.
- Photos are part of the medical record.
- Photos may be stored outside of the medical records department (just as x-ray films are stored in the radiology department).
- Follow HIPPA compliance policies for release of all records including photos.
- Photos may be released to law enforcement with proper authorization.
- Follow medical records retention rules regarding disposal of photographs.
- Because of the extremely confidential nature of colposcopy photos, these photos are not released like other portions of the medical record.
  - Colposcopy or genital/anal photos are released only in response to a subpoena and then are released directly to the medical expert who will review the photos.
EMERGENCY CONTRACEPTION

- Levonorgestrel (Plan B One-Step or Next Choice, 1.5 mg po x 1) is most effective if taken early, but has efficacy up to 120 hours after unprotected intercourse.
  - Mechanism of action: Inhibition or delay of ovulation; interference with fertilization or tubal transport; prevention of implantation by altering endometrial receptivity; causing regression of the corpus luteum.
  - Does not disrupt an established pregnancy.
  - Effectiveness: if taken with first 72 hours, 89% reduction in pregnancies in large prospective studies.
- Ulipristal (brand name ella) is a selective progesterone receptor modulator with primarily antiprogestin activity. It is as effective as levonorgestrel, and can be given up to 120 hours after unprotected intercourse.
- Discuss and provide emergency contraception when:
  - Patient is Tanner Stage 3 or above, even if premenarchal AND
  - There is a reasonable concern for semen – vaginal contact (even if a condom was used) AND
  - Sexual contact occurred within prior 120 hours AND
  - Patient feels any pregnancy conceived in the last five days would be undesirable to continue AND
  - Pregnancy test is negative.
- Side effects:
  - Nausea (18%) vomiting (4%) with levonorgestrel.
  - If vomiting occurs within 1 hour of dose administration, may give an antiemetic and repeat the dose.
  - If patient has not had a previous menstrual period, advise that there may be bleeding within a few days.
  - For post-menarchal patients, irregular menses may occur within the next week and month.
- In Washington the patient of any age has the right to confidential care for reproductive health, in practical terms patients under 12 years may not have the cognitive ability to provide informed consent. In these cases the parent or guardian must be informed and assist in decision making.
HIV RISK ASSESSMENT AND POST EXPOSURE PROPHYLAXIS – DETAIL

- The decision to recommend HIV post-exposure prophylaxis depends on local epidemiology and a case by case assessment of risk factors of the assailant and details of contact.
- HIV PEP if indicated, must be started within 72 hours of contact, and continued for 28 days.
- The risk of HIV transmission from a positive source in a single act of receptive vaginal intercourse is estimated to be 1 per 1,000. The risk of transmission from a positive source in a single act of anal receptive intercourse is 1 per 200.
- The risk for an individual patient are extremely difficult to calculate, since details about the assailant’s risk factors and HIV status are usually unknown.
- It is not feasible to wait for HIV serologic tests in the assailant even if the assailant has been already arrested. This testing may take weeks to accomplish.
- HIV PEP may be indicated when:
  - Sexual contact was within prior 72 hours AND
  - There was probable semen to mucosa contact.
  - Contact was by a man at high risk (esp. man who has sex with men) OR
  - There was more than one offender OR
  - There was penile anal penetration OR
  - The victim has grossly identifiable genital or anal injury skin disruption OR
  - Family has a high concern for HIV infection, after discussion of low relative risk.
- If HIV PEP is recommended, consult promptly with a specialist in pediatric infectious disease.
  - Baseline labs are: CBC and platelets, liver function tests, HIV serology, creatinine: treatment should not be delayed while awaiting results.
- Assistance with postexposure prophylaxis decisions can be obtained by calling the National Clinician's Post-Exposure Prophylaxis Hotline (PEPLine), telephone: 888-448-4911.
- Provide a limited number of days of medication to start, many patients will decide to not continue in completing the full course of treatment.
- Follow-up, including one visit during treatment and HIV serology follow-up must be arranged.
- Crime Victim’s Compensation will pay for the initial 3 days of medication.
- The complete 28 day course may be covered by patient’s own insurance or by CVC, if an application is completed and approved.
SEXUALLY TRANSMITTED DISEASES IN CHILDREN - DETAIL

GENERAL

- STDs are rare in children, but identification can be critical in assessing child sexual abuse.
- In general, any positive test should be retested before treatment is initiated. If available, an alternative testing technique should be used.
- Labs should preserve the initial specimen whenever possible.
- Diagnosis of one STD should prompt testing or evaluation for other STDs.

References

Hammerschlag MR, Guillén CD. Medical and legal implications of testing for sexually transmitted infections in children. Clin Microbiol Rev. 2010


CDC Sexually Transmitted Disease Guidelines 2010

GONORRHEA

- Gonorrhea confirmed by culture (or 2 NAATs) is diagnostic of sexual abuse if perinatal transmission is ruled out.
- Report confirmed infection to CPS or law enforcement.

Symptoms

- Most girls with vaginal gonorrhea are symptomatic (vaginal discharge). However, some girls are asymptomatic.
- Most patients with pharyngeal or anal gonorrhea are asymptomatic.

Testing

- Children should not be treated for gonorrhea or chlamydia before confirmatory tests are performed.
- Culture requires selective media, and confirmation to differentiate other Neisseria species.
- Nucleic acid amplification test performed on “dirty catch” urine specimen is a good screening test. A positive result should prompt repeat testing by culture or by a second, alternate technology NAAT. Lab should retain specimen for future testing.
- A positive NAAT will persist for weeks after effective treatment.
- Nucleic acid amplification tests are not approved by the FDA for use at oral or anal sites. However, the CDC noted that individual laboratories or collaborating laboratories may offer testing for extragenital gonorrhea or chlamydia if internal validation of the method by a verification study is performed.

[cont']
**CHLAMYDIA TRACHOMATIS**

- Confirmed chlamydia vaginal or anal infection in a child is diagnostic of sexual abuse if perinatal transmission is ruled out.
- **Report** confirmed infection (not perinatal infection) to CPS or law enforcement.

**Symptoms**

- Frequently asymptomatic, can persist for months or years

**Testing**

- Chlamydia infection must be confirmed by culture or 2 different NAATs.
- Urine testing by NAAT is acceptable as an initial test. Lab should retain specimen for further tests.
- Anal testing by chlamydia culture, or by NAAT if the local lab has validated, is recommended for boys and girls.
- Urethral swabs for boys (either culture or NAAT) are not recommended.
- Pharyngeal swabs (either culture or NAAT) are not recommended.
- Perinatally transmitted chlamydia has been demonstrated to persist for at least 33 months.
  - Most women in the US are tested for chlamydia during pregnancy, so it may be important to review birth records. Many children are treated early with azithromycin for otitis or other common infections, and this would eliminate chlamydia as well.
- A positive NAAT will persist for weeks after effective treatment.

**TRICHOMONAS**

- Confirmed vaginal trichomonas infection is highly suspicious for child sexual abuse.
- **Report** confirmed trichomonas infection (not perinatal infection) to CPS or law enforcement.

**Symptoms**

- Data limited in children. In teens, vaginal discharge.

**Testing**

- Rarely, *T. vaginalis* can be transmitted vertically from mother to infant (vaginal and urine) during birth. These infections may persist for up to 9 months after birth.
- *T. hominis*, a non-pathogenic intestinal flagellate, is very similar to *T. vaginalis* on microscopy. Care should be taken in diagnosing Trichomonas on a urine specimen, as there could be fecal contamination.
- Confirmation can be by culture (Diamond’s media) or the commercial “In Pouch” culture system. A variety of non-culture tests have been developed. None have yet been validated in children.
SYPHILIS
- Confirmed postnatally acquired syphilis is diagnostic of sexual abuse and requires a mandatory report to CPS or law enforcement.

Symptoms
- May have cutaneous signs, but most are asymptomatic.

Testing
- Prevalence of syphilis in sexually abused children is very low.
- Testing is not recommended routinely, except in high risk situations.
- Differentiating perinatal from later acquired syphilis may be challenging.
- Serology: non-treponemal test (e.g. RPR) followed by *T. pallidum* specific test.
- Obtain 8 weeks after sexual abuse contact.

GENITAL HERPES SIMPLEX
- Genital herpes, either type I and type 2, is suspicious for child sexual abuse if self inoculation has been ruled out.
- Report confirmed genital herpes to CPS or law enforcement when suspected sexual transmission.

Symptoms
- Dysuria, genital or perianal vesicles or ulcers. Primary infection may be accompanied by malaise and fatigue.

Transmission
- A child with herpes gingivostomatitis may self-inoculate by touching infected saliva to other body sites.
- An adult with oro-labial herpes might transmit infection during diaper changes if infected material touched the adult's hand and then touched the diaper region.

Testing
- Culture: If intact vesicles are present, unroof a vesicle or two and swab the base. Place directly into viral culture media.
- Direct fluorescent antibody: this test is specific and reproducible for adults, but as of 2011 has not been evaluated or cleared for use in children. Culture is preferred if there may be legal issues.
- Serology: if lesions are crusted, acute and convalescent sera can be tested. Type specific serology by Western Blot can be obtained through the University of Washington.
GENITAL WARTS

- Human papilloma virus causes genital warts. In a child older than age 2 or 3 genital warts are suspicious for sexual abuse.
- The older the child, the more concerning genital warts are for sexual abuse.
- Report to CPS or law enforcement if child is out of diapers, or if additional concerns.
- Diagnosis is by clinical inspection. Care should be taken to differential molluscum, skin tags, and condyloma lata.
- Vertical transmission is thought occur prenatally or perinatally from an infected mother.
- Postnatal infection is believed to occur from hand to diaper area transmission from infected parent or caregiver.
- Latency period may be months.

Testing

- Biopsy is not recommended, type specific assays are only available to identify high malignancy potential types.

HIV

- The decision to recommend HIV testing depends on local epidemiology, and a case by case assessment of risk factors of the assailant and details of contact.
- The risk for an individual patient is extremely difficult to calculate, since details about the assailant's risk factors and HIV status are usually unknown.
- The risk of HIV transmission from a positive source in a single act of receptive vaginal intercourse is estimated to be 1 per 1,000. The risk of transmission from a positive source in a single act of anal receptive intercourse is 1 per 200. The risk from penile-oral or vaginal-oral is extremely low.

HIV Testing

- Testing, if done, should be at baseline (within 2 weeks of contact), 6 weeks, 12 weeks, and 24 weeks after contact.
- See CDC Sexually Transmitted Disease Guidelines 2010
NON- SEXUALLY TRANSMITTED DISEASES

VULVOVAGINITIS
- Is common in pre-pubertal girls, and is usually due to irritation or infection with non-sexually transmitted organism.
- If there is a vaginal discharge, swab the posterior fourchette and send for routine wound culture and gonorrhea culture.
- Candida vulvovaginitis is very uncommon in girls who are out of diapers and pre-pubertal. Vaginal discharge or irritation should not be assumed to be candida and inappropriately treated with anti-fungal creams.

BACTERIAL VAGINOSIS
- Is considered non-specific for sexual abuse in children.
- Medical follow-up is recommended.
FOLLOW-UP MEDICAL CARE - DETAIL

- Follow-up medical visit by primary or specialized medical provider is recommended in 1-3 weeks after initial exam.
- This visit is typically not covered by CVC, unless it is done to complete the initial acute exam.

REVIEW WITH PATIENT AND PARENT

- Acute exam findings
- Medical lab results, if any (crime lab results will not be available)
- Current physical symptoms
- Emotional reactions (sleep disorders, anxiety, depressive symptoms, behavior problems)
- Current family functioning. Assess social support (family, friends)
- Concerns for safety and legal issues. Contact with police and CPS
- Concerns regarding STDs and HIV

PHYSICAL EXAM

- Individualize exam, depending on history and symptoms
- Check for resolution of injury
- Evaluate any new symptoms
- Refer for ongoing medical care, if needed

LAB TESTS

- Depends on risks and patient concerns
- Pregnancy test if risk of pregnancy
- Test for gonorrhea and chlamydia, depending on nature of contact
- Syphilis test (RPR) 6 weeks after possible exposure if high risk contact

HIV TESTING

- If indicated, and if parent wishes:
  - Baseline, 6 weeks, 12 weeks, and 24 weeks after sexual contact

HEPATITIS B VACCINE

- Complete 3 vaccine series, adhering to timelines of immunization recommendations

REFER

- Refer for follow-up medical care, counseling, and advocacy

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