Approach to the Acute Sexual Assault Patient in the ED

Jamie Kondis MD
Instructor in Pediatrics
Washington University School of Medicine
21st Annual Clinical Advances in Pediatric Emergency Medicine
April 5, 2014
• I have no financial disclosures
Objectives:

• Describe guidelines for when to perform evidence collection, laboratory testing and prophylaxis in the case of an acute sexual assault

• Review the algorithm for dealing with a sexual assault pediatric patient in Missouri
Sexual Assault in the ED

• By age 18 years, 1 in 5 females are sexually abused and 1 in 9 males are sexually abused
• Many of these children will not disclose their abuse until adulthood, but some will disclose prior to that, and should be offered a medical evaluation
• All children who have experienced sexual abuse should be offered an evaluation by a medical provider trained in sexual and physical abuse evaluations
• Should this be done in the ED?
Sexual Assault in the ED

• In Missouri the Sexual Assault Forensic Examination-Child Abuse Resource and Education (SAFE-CARE) Network is a network of providers who have received specialized training in the medical evaluation of child maltreatment.

• The SAFE-CARE providers
  – provide comprehensive medical evaluations for all forms of child maltreatment
  – collaborate with local agencies responsible for child maltreatment investigations
  – have the support of child abuse pediatric experts across the state for case review and mentorship
Sexual Assault in the ED

• The SAFE-CARE Advisory Council developed a screening protocol for sexual assault victims. Its purpose is to guide the determination of whether a child requires an immediate intervention or direct the care to a provider for a scheduled comprehensive evaluation.

• A child who does not require emergency services will be more effectively served by being offered a medical evaluation by a trained provider during regular hours.
A Medically-Based Screening Protocol for the Medical Response to Child Sexual Abuse/Assault

All children who are suspected victims of child sexual abuse should be offered a timely medical evaluation by a provider skilled in performing such evaluations. The primary purpose of the medical evaluation is to identify, document, diagnose, prevent, and treat medical conditions and/or trauma (resulting from abuse and unrelated to abuse), as well as to assess issues related to patient safety and wellbeing. An additional purpose of the medical evaluation is to determine the appropriateness of trace evidence collection and, if indicated, to ensure that biologic trace materials are properly collected and preserved.

The Missouri Sexual Assault Forensic Examination-Child Abuse Resource and Education (SAFE-CARE) Network is a network of medical providers who have received specialized training in the medical evaluation of child maltreatment. These SAFE-CARE providers can provide comprehensive, state-of-the-art medical evaluations to alleged child victims in a child-friendly setting and will frequently collaborate with local agencies responsible for child maltreatment investigations.

To find a SAFE-CARE Provider serving your community, call 800-TEL-LINK (800-835-5465). TEL-LINK is the Missouri Department of Health and Senior Services’ toll-free information and referral line for maternal and child health care. TEL-LINK is answered weekdays from 8:00 a.m. to 5:00 p.m. Central Standard Time. Recorded messages are taken at other times; these calls will be returned during normal business hours.

A medically-based screening process can guide health providers and community partners in determining whether a child requires an immediate medical examination by an emergency health provider, mental health provider, or social worker. A child who does not require emergency services will be more effectively served by being offered a medical evaluation by a SAFE-CARE Network provider during regular clinic hours.

While most child victims of sexual abuse/assault do not require emergency medical evaluations, reasons for emergency medical examinations include, but are not limited to:

- The alleged assault may have resulted in the transfer of trace biological material and occurred within the previous 3 days (or other locally determined interval up to 7 days).
- The alleged assault may have placed the child at risk for pregnancy and occurred in the previous 5 days.
- The child complains of pain in the genital or anal area.
- There is evidence or complaint of anogenital bleeding or injury.

Reasons for emergency mental health or social interventions include, but are not limited to:

- Intervention is needed emergently to assure the safety of the child.
- The child is experiencing significant behavioral or emotional problems that could make the child a danger to themselves or others.

The Child Abuse Medical Resource Centers share responsibility of training, support, and mentoring of medical professionals working with child physical and sexual abuse issues. Medical providers in need of expert consultation or patient transport may call the 24-hour access lines maintained by these Resource Centers for assistance:

St. Louis Children’s Hospital: Children’s Direct Access Line 800-678-HELP (800-678-4357)
SSM Cardinal Glennon Children’s Medical Center: Access Center 888-229-2424
Children’s Mercy Hospital Kansas City: 800-GO-MERCY (800-466-3729)
A child has disclosed sexual abuse, abuse was witnessed, or there is other credible concern that a child was sexually abused.

Make a Child Abuse/Neglect Report to Missouri Children’s Division 800-392-3738

Could the contact have resulted in transfer of biologic evidence?

- Yes
  - Is it possible that the contact occurred in the last 3 days (or other locally agreed time interval up to 7 days)?
    - Yes: Emergency medical care, to include possible trace evidence collection and possible prophylactic medications, should be provided in the nearest appropriate facility. Contact local SAFE-CARE provider to determine appropriate follow-up care.
    - No: Is the child at risk of pregnancy?
      - Yes: Is it possible that the contact leading to that pregnancy risk occurred in the last 5 days?
        - Yes: Emergency medical care, to include possible offer of pregnancy prophylaxis, should be provided in the nearest appropriate facility. Then contact local SAFE-CARE provider to determine appropriate follow-up care.
        - No: Emergency medical care should be provided in the nearest appropriate facility. Then contact local SAFE-CARE provider to determine appropriate follow-up care.
      - No: Is the child experiencing symptoms of pain or bleeding?
        - Yes: Emergency social intervention should be provided in the nearest appropriate facility, which may be a medical facility. Then contact local SAFE-CARE provider to schedule a comprehensive sexual abuse medical evaluation.
        - No: Is the child displaying behavioral or emotional problems that put themselves or others in danger?
          - Yes: Emergency mental health care should be provided in the nearest appropriate facility, which may be a medical facility. Then contact local SAFE-CARE provider to schedule a comprehensive sexual abuse medical evaluation.
          - No: Is an emergent intervention needed to assure the safety of the child?
            - Yes: Contact your local SAFE-CARE provider to determine if and/or when a scheduled comprehensive sexual abuse medical evaluation is recommended.
            - No: Contact your local SAFE-CARE provider to determine if and/or when a scheduled comprehensive sexual abuse medical evaluation is recommended.
When to Refer to the PED?

A child has disclosed sexual abuse, abuse was witnessed, or there is other credible concern that a child was sexually abused.

Make a Child Abuse/Neglect Report to Missouri Children’s Division 800-392-3738
Mandated Reporting

- In Missouri, all healthcare providers are mandated reporters. (Laws vary by state).
- (MO Child abuse hotline: 1-800-392-3738. IL Child abuse hotline: 1-800-25-ABUSE)
- Failure to report abuse is a Class A Misdemeanor which can result in jail time and/or a fine
- Per Missouri state statute, when a mandated reporter “has reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which would reasonably result in abuse or neglect, that person shall immediately report to the division”
Could the contact have resulted in transfer of biologic evidence?

- Yes
  - Is it possible that the contact occurred in the last 3 days (or other locally agreed time interval up to 7 days)?
    - Yes
      - Emergency medical care, to include possible trace evidence collection and possible prophylactic medications, should be provided in the nearest appropriate facility. Contact local SAFE-CARE provider to determine appropriate follow-up care.
    - No
      - Is the child at risk of pregnancy?
        - Yes
          - Female with signs of pubertal development (such as breast development) and penile-vaginal contact is suspected
            - Is it possible that the contact leading to that pregnancy risk occurred in the last 5 days?
              - Yes
                - Emergency medical care, to include possible offer of pregnancy prophylaxis, should be provided in the nearest appropriate facility. Then contact local SAFE-CARE provider to determine appropriate follow-up care.
              - No
            - No
              - Emergency medical care, to include possible trace evidence collection and possible prophylactic medications, should be provided in the nearest appropriate facility. Contact local SAFE-CARE provider to determine appropriate follow-up care.
        - No
          - Is the child at risk of pregnancy?
            - Yes
              - Female with signs of pubertal development (such as breast development) and penile-vaginal contact is suspected
                - Is it possible that the contact leading to that pregnancy risk occurred in the last 5 days?
                  - Yes
                    - Emergency medical care, to include possible offer of pregnancy prophylaxis, should be provided in the nearest appropriate facility. Then contact local SAFE-CARE provider to determine appropriate follow-up care.
                  - No
                - No
                  - Emergency medical care, to include possible trace evidence collection and possible prophylactic medications, should be provided in the nearest appropriate facility. Contact local SAFE-CARE provider to determine appropriate follow-up care.
            - No
              - Emergency medical care, to include possible trace evidence collection and possible prophylactic medications, should be provided in the nearest appropriate facility. Contact local SAFE-CARE provider to determine appropriate follow-up care.

- No
  - No
Trace Evidence Collection

• The American Academy of Pediatrics recommends that forensic evidence collection be considered for up to 72 hours post assault.

• This time frame was initially devised following studies of adult women after sexual intercourse and adult rape victims.

• Prepubertal children are unlikely to have body swab evidence beyond 24 hours.

• Recent retrospective studies have supported this data but still encourage collecting evidence in prepubertal children beyond 24 hours.
Collection of Forensic Evidence From Pediatric Victims of Sexual Assault

Rebecca Girardet, MD\(^1\), Kelly Bolton, RN\(^1\), Sheela Lahoti, MD\(^1\), Hillary Mowbray, MD\(^2\), Angelo Giardino, MD\(^2\), Reena Isaac, MD\(^3\), William Arnold, MBA\(^4\), Breanna Mead, MS\(^5\), Nicole Paes, MS

Forensic Evidence Collection and DNA Identification in Acute Child Sexual Assault

Jonathan D. Thackeray, MD\(^1\), Gail Hornor, CPNP\(^2\), Elizabeth A. Benzinger, PhD\(^3\), Philip V. Scribano, DO, MSCE\(^2\)
Trace Evidence Collection

• In both studies, factors associated with both a positive evidence-collection kit and DNA detection on univariate analysis include a reported history of perpetrator ejaculation, a disclosure of genital-genital and/or anal-genital contact, and not having bathed and/or changed clothing before the collection.

• Identifiable DNA was collected from a child's body despite cases in which: evidence collection was performed >24 hours beyond the assault; the child had a normal/nonacute anogenital examination; there was no reported history of ejaculation; and the victim had bathed and/or changed clothes before evidence collection.

• Failure to conduct evidence collection on prepubertal children beyond 24 hours after the assault will result in rare missed opportunities to identify forensic evidence, including identification of DNA.
Trace Evidence Collection

• In Missouri, time frames for trace evidence collection may vary slightly
• It is well established that trace evidence collection from a child’s body site should never be attempted beyond seven days
• Clothing or bedding from the scene may yield positive results for a much longer period of time
Could the contact have resulted in transfer of biologic evidence?

Yes

Is it possible that the contact occurred in the last 3 days (or other locally agreed time interval up to 7 days)?

Yes

Emergency medical care, to include possible trace evidence collection and possible prophylactic medications, should be provided in the nearest appropriate facility. Contact local SAFE-CARE provider to determine appropriate follow-up care.

No

Is the child at risk of pregnancy?

- female with signs of pubertal development (such as breast development) and
- penile-vaginal contact is suspected

Yes

Is it possible that the contact leading to that pregnancy risk occurred in the last 5 days?

Yes

Emergency medical care, to include possible offer of pregnancy prophylaxis, should be provided in the nearest appropriate facility. Then contact local SAFE-CARE provider to determine appropriate follow-up care.

No

No
Could the contact have resulted in transfer of biologic evidence?

Yes

Is it possible that the contact occurred in the last 3 days (or other locally agreed time interval up to 7 days)?

Yes

Emergency medical care, to include possible trace evidence collection and possible prophylactic medications, should be provided in the nearest appropriate facility. Contact local SAFE-CARE provider to determine appropriate follow-up care.

No

Is the child at risk of pregnancy?
- female with signs of pubertal development (such as breast development) and
- penile-vaginal contact is suspected

Yes

Is it possible that the contact leading to that pregnancy risk occurred in the last 5 days?

Yes

Emergency medical care, to include possible offer of pregnancy prophylaxis, should be provided in the nearest appropriate facility. Then contact local SAFE-CARE provider to determine appropriate follow-up care.

No
STD Testing/Prophylaxis

Morbidity and Mortality Weekly Report
www.cdc.gov/mmwr

Recommendations and Reports
December 17, 2010 / Vol. 59 / No. RR-12
STD Testing/Prophylaxis

• CDC guidelines use 72 hours as a cut-off for prophylactic antibiotics for sexually transmitted diseases and for prophylaxis for HIV

• Local prevalence patterns of STD’s should also be taken into consideration
STD Testing/Prophylaxis

• Per the CDC, Presumptive treatment for children who have been sexually assaulted or abused is not recommended because
  – 1) the incidence of most STDs in children is low after abuse/assault,
  – 2) prepubertal girls appear to be at lower risk for ascending infection than adolescent or adult women
  – 3) regular follow-up of children usually can be ensured.
STD Testing/Prophylaxis

• If choosing to place a patient (of any age) on HIV prophylaxis, the first dose should be given as quickly as possible.

• The regimen should be decided upon by local infectious disease specialists based on local HIV susceptibilities.

• For children receiving antiretroviral PEP, provide enough medication to last until the return visit at 3–7 days after the initial assessment, at which time the child should be reevaluated and tolerance of medication assessed; dosages should not exceed those for adults.

• Perform HIV antibody test at original assessment, 6 weeks, 3 months, and 6 months.
Follow Up Care

• At St. Louis Children’s Hospital, all patients placed on HIV prophylaxis are seen in follow up at one week at either the Sexual Abuse Management (SAM) clinic or the ID clinic

• Patients are given a ten day supply of medications and are given the remaining 18 days in follow up (total of 28 days of prophylaxis)

• Patients not on HIV prophylaxis are seen in 2 weeks for repeat STD testing and physical examination
Could the contact have resulted in transfer of biologic evidence?

Is it possible that the contact occurred in the last 3 days (or other locally agreed time interval up to 7 days)?

Yes

Is the child at risk of pregnancy?
- female with signs of pubertal development (such as breast development) and
- penile-vaginal contact is suspected

No

Is it possible that the contact leading to that pregnancy risk occurred in the last 5 days?

No

Yes

Emergency medical care, to include possible trace evidence collection and possible prophylactic medications, should be provided in the nearest appropriate facility. Contact local SAFE-CARE provider to determine appropriate follow-up care.

Emergency medical care, to include possible offer of pregnancy prophylaxis, should be provided in the nearest appropriate facility. Then contact local SAFE-CARE provider to determine appropriate follow-up care.
Could the contact have resulted in transfer of biologic evidence?  

Yes: Is it possible that the contact occurred in the last 3 days (or other locally agreed time interval up to 7 days)?

Yes: Emergency medical care, to include possible trace evidence collection and possible prophylactic medications, should be provided in the nearest appropriate facility. Contact local SAFE-CARE provider to determine appropriate follow-up care.

No: Is the child at risk of pregnancy?  
- female with signs of pubertal development (such as breast development) and 
- penile-vaginal contact is suspected

No: Is it possible that the contact leading to that pregnancy risk occurred in the last 5 days?

Yes: Emergency medical care, to include possible offer of pregnancy prophylaxis, should be provided in the nearest appropriate facility. Then contact local SAFE-CARE provider to determine appropriate follow-up care.
Risk of Pregnancy

• Pregnancy testing should be done on all females who have:
  – History of menarche or SMR of 3 or greater, and
  – Suspected penile-vaginal contact (with or without penetration, condom or ejaculation) and
  – Contact occurred in the previous 5 days.

• If pregnancy testing is negative, pregnancy prophylaxis is available and should be offered to these patients.

• At SLCH, Plan B prophylaxis is offered to these patients as a one-time dose in the ED. Pregnancy prophylaxis refusal should be documented.
Could the contact have resulted in transfer of biologic evidence?

- No

  Is the child at risk of pregnancy?
  - female with signs of pubertal development (such as breast development) and penile-vaginal contact is suspected
  
  - Yes
  
  Is it possible that the contact leading to that pregnancy risk occurred in the last 5 days?
  
  - Yes
    
    Emergency medical care, to include possible prophyllactic medications, should be provided in the nearest appropriate facility. Then contact local SAFE-CARE provider to determine appropriate follow-up care.
  
  - No
    
    Emergency medical care, to include possible trace evidence collection and possible prophyllactic medications, should be provided in the nearest appropriate facility. Contact local SAFE-CARE provider to determine appropriate follow-up care.

  - No

Is it possible that the contact occurred in the last 3 days (or other locally agreed time interval up to 7 days)?

- Yes

  Emergency medical care, to include possible trace evidence collection and possible prophyllactic medications, should be provided in the nearest appropriate facility. Contact local SAFE-CARE provider to determine appropriate follow-up care.
Is the child experiencing symptoms of pain or bleeding?

No

Is the child displaying behavioral or emotional problems that put themselves or others in danger?

No

Is an emergent intervention needed to assure the safety of the child?

No
Acute Pain and Bleeding

• May represent traumatic injury from abuse
• May represent related medical disease
• May represent unrelated medical disease
• Should be addressed in the ED, may not necessarily need reported for abuse
• May need Pediatric Gynecology consult
Is the child experiencing symptoms of pain or bleeding?

Yes

No

Is the child displaying behavioral or emotional problems that put themselves or others in danger?

Yes

No

Is an emergent intervention needed to assure the safety of the child?

Yes

No
Behavior/Emotional Problems

• May require crisis counseling/referral
• May require full mental health evaluation
• May require emergency mental health treatment plan
• An appropriate medical/mental health provider should evaluate any concern that a child’s behavior represents a danger to themselves or others (including SI/HI)

Is the child displaying behavioral or emotional problems that put themselves or others in danger?

Yes

Emergency mental health care should be provided in the nearest appropriate facility, which may be a medical facility. Then contact local SAFE-CARE provider to schedule a comprehensive sexual abuse medical evaluation.

No
Is the child experiencing symptoms of pain or bleeding?

No

Is the child displaying behavioral or emotional problems that put themselves or others in danger?

No

Is an emergent intervention needed to assure the safety of the child?

Yes
Ensuring the Child’s Safety

• A child victim of sexual abuse should be protected from possible perpetrators during the ensuing investigation.
• This may require intervention from Children’s Division, Law Enforcement, or Juvenile Court to ensure a safe discharge.
• Social Work assistance will be necessary for these patients.

Is an emergent intervention needed to assure the safety of the child? Yes

Emergency social intervention should be provided in the nearest appropriate facility, which may be a medical facility. Then contact local SAFE-CARE provider to schedule a comprehensive sexual abuse medical evaluation.
What If You Did Not Answer “Yes” To Any Of These Questions?

No

Contact your local SAFE-CARE provider to determine if and/or when a scheduled comprehensive sexual abuse medical evaluation is recommended.
Referring to Clinic Instead of the ED

• These patients can be scheduled for a comprehensive evaluation by a SAFE-CARE provider, or at a SAFE-CARE resource center (SAM clinic at SLCH, Cardinal Glennon or Kansas City Children’s Mercy) at a convenient time during the day.
SANE Programs

• SANE, or sexual assault nurse examiners are registered nurses or nurse practitioners who have completed specialized education and clinical preparation in the medical forensic care of the patient who has experienced sexual assault or abuse.

• The SANE normally works in concert with a collaborative, multidisciplinary group of professionals to develop a plan of care for the patient at discharge.
SANE Programs

• The SANE performs medical forensic history, a detailed physical and emotional assessment, written and photographic documentation of injuries, collection and management of forensic samples, and providing emotional and social support and resources.

• The SANE also can testify in any legal proceedings related to the examination and ensures the proper chain of custody and integrity of the samples is maintained so that the evidence will be admissible in court.
SANE Programs

• SANEs receive training to become either SANE-A (adult and adolescent >15 yrs populations) or SANE-P (pediatric population)
• This training involves completion of a 40 hour classroom experience and a clinical component. SANEs then have the opportunity to take a board examination through the International Association of Forensic Nursing
• Missouri currently has a well-established SANE-P program and training course at Children’s Mercy Hospital in Kansas City, as well as many SANE nurses who are SAFE-CARE providers throughout the state
Impact of Sexual Assault Nurse Examiners on the Evaluation of Sexual Assault in a Pediatric Emergency Department

Kirsten Bechtel, MD, Elizabeth Ryan, RN, and Deborah Gallagher, RN

Pediatric sexual assault nurse examiner care: Trace forensic evidence, ano-genital injury, and judicial outcomes

Gail Hormor, RNC, DNP, CPNP, SANE-P, Jonathan Thackeray, MD, Philip Scribano, DO, Sherry Curran, MS, and Elizabeth Benzinger, PhD

Nationwide Children’s Hospital, Columbus, Ohio
Pediatric SANE Programs

• Pediatric SANE programs have been shown to improve rates of STD testing, pregnancy prophylaxis and referrals to counseling programs of sexual assault victims vs patients who presented to a PED before a SANE program was established.

• In another study, detection and documentation of ano-genital injury, evaluation and documentation of pregnancy status, and testing for N. gonorrhea and C. trachomatis was significantly improved after implementation of the P-SANE Program compared to the historical control.
Questions?

• Call the Child Protection Program, St. Louis Children’s Hospital
  – Office number: 314-454-2879 (M-F normal business hours)
  – Or any date/time, via Children’s Direct (800.678.HELP)
References: