**PEDIATRIC SEXUAL ABUSE/ASSAULT**

SANE room 47-C. Door code 1-4-5. Press each number individually.

When it is suspected that a pediatric patient may have been sexually abused, the child should receive a screening exam in the ED that focuses on acute problems (ie: trauma, bleeding, vaginal discharge) and if needed, evidence collection.

**OBTAINING HISTORY**

- Interview caregivers independently of each other and the child. Document who was present for the interviews and the demeanor of the caregivers. Use quotation marks to indicate specific responses by the caregivers.
- While detailed interviewing of children should be deferred to professionals with expertise, the child may be asked broad, open-ended questions to obtain a history and focus for the physical examination. When possible, the child should be interviewed away from the caregivers. Document who was present for the interview, the child’s demeanor, and use quotation marks to indicate statements by the child.

**PHYSICAL EXAM**

- MD is to complete a head to toe exam. Do a thorough visual anogenital exam to assess for possible injuries, lesions.
- **A SPECULUM SHOULD NEVER BE USED ON A PRE-PUBERTAL FEMALE AND IS RARELY NEEDED IN ADOLESCENTS.** If a speculum exam is warranted for any medical reason (ie. unknown source of bleeding, evaluation of trauma, removal of foreign body resistant to being flushed out of vagina) the pre-pubertal child should be examined under general anesthesia/conscious sedation.
- **A child beyond infancy SHOULD NOT be physically restrained for the physical exam.** Consideration should be given to deferring the exam to the child abuse specialist in cases where it is not immediately medically necessary to examine the child/adolescent and they are unable to cooperate in the ED with the exam.
- When possible, photographs (permission not required) should be taken with the SANE camera to document findings. An identifying face photo is the first photo with pt name, MR#, date and time of photos, and by whom. Forensic photos should not be loaded into the chart when avoidable.
- A normal exam does not rule out sexual assault/abuse.
- **Evidence collection kits need to be collected within the first 72 hours post assault for pre-pubertal and within 150 hours for pubertal.**
- Collect a Drug Facilitated Sexual Assault Collection Kit when illicit substances are suspected.
INDICATIONS FOR PEDIATRIC STI SCREENING & TREATMENT

What to screen for in a pre-pubertal patient is not as clear cut as for the rest of the population. When in doubt, page BEACON.

Pre-pubertal

- Vaginal discharge present – collect dirty urine for GC/Chlamydia & swab for trichomonas
  - The collection of Chlamydia/Gonorrhea NAA is very specific. The child should not have voided for one hour prior to this sample collection. Do not use obstetrical wipes; mark the cup at 30ml line. Explain to caregiver to collect more than 2 ml and less than 30 ml of the first stream of urine. Instruct them not to pour off excess.
- Genital/rectal lesions – collect dirty urine for GC/Chlamydia & swab un-roofed lesion
- Genital, oral, or anal trauma
- Evidence of ejaculation
- History suggests genital, oral, or anal penetration
- With a confirmed STI in another child @ their residence
- Confirmed STI in perpetrator
- Consider pharyngeal testing if oral-genital contact, c/o of sore throat

Treatment –

- STI prophylaxis & HIV nPEP is generally not indicated.
- If STI test is positive, consult Beacon MD on call prior to treatment.
- Dr. Belhorn must be consulted before HIV nPEP is given to anyone under the age of 18yo.

Pubertal

Vicims of an acute assault should have the following tests done. Collect specimens from any site of possible, attempted, or confirmed penetration.

- U-preg – must be negative prior to giving ella.
- GC/Chlamydia
  - dirty urine
  - Swab – rectal, pharyngeal, cervix/vaginal, or male urethra
- Trichomonas – Rapid Trichomonas Antigen test
  - White topped culture swab placed in vagina for 30 seconds
  - White topped culture swab placed in male urethra for 30 seconds
- HIV
- RPR

Other possible tests that may be indicated:

- Hep B surface antigen and antibody (if not fully immunized)
- Hep C PCR
  - If perpetrator is Hep C +, drug user, or has been incarcerated
- HSV
  - If vesicle present culture swab of un-roof lesion
Treatment –
- Emergency contraception, ella, is always offered when applicable.
- Testing before treatment is required.
- If STI test is positive, consult Beacon MD on call prior to treatment.
- Dr Belhorn must be consulted before HIV nPEP is given to anyone under the age of 18yo.

**FINAL DIAGNOSIS**
In most cases the “Final Diagnosis” will not be made in the ER setting but rather by a follow-up evaluation by the child abuse specialist. Therefore, use caution in the wording of the preliminary assessment (i.e. “no sexual abuse found”)

**REFERRALS**
BEACON Child Evaluation Clinic - Send an email about referral for all PEDS abuse/assault cases 17yo and younger. Include the following information:
- Patient name, MR#, and DOB
- Reason for referral (medical f/u, seen in ED for suspected sexual assault)
- Names of all agency representatives involved in the case with contact info (law enforcement, CPS)
- Contact numbers for family, preferably two
- Are there any language barriers for the family? Will BEACON need interpreter services?
  cec@unchealth.unc.edu
  sarakirk2@unchealth.unc.edu
  samantha_schilling@meds.unc.edu
  deborah_flowers@med.unc.edu

HIV nPEP recommendations - Page Peds ID Dr. Tom Belhorn for all pediatric sexual assaults
If HIV PEP recommended & initiated:
- Ensure correct medication and weight based dosing.
- Document in EPIC the initiation of HIV nPEP and the best contact number for the patient.
- Email Belhorn with peds case referral info.
If HIV PEP not recommended & not initiated:
- Document in EPIC that Dr. Belhorn was contacted and that no order for HIV PEP was given.

**SAFETY/REPORTING**
- A DSS report is mandatory when there is suspected or confirmed abuse or neglect of a juvenile by a parent, care taker, or other individual in the home. The report should be made to the county where the child resides. If you are unable to connect with the DSS in the county of residence you may contact Orange Co. DSS to make the report. [http://www.ncdhhs.gov/dss/local/](http://www.ncdhhs.gov/dss/local/) All citizens of NC who have suspicion of child abuse/neglect are mandatory reporters. Hospital policy also requires it.
  - The reporting person needs to complete the Safety Considerations Form.
• If the patient is admitted inpatient, then notify the individuals identified below of the Completed Safety Considerations Form:
  o Assigned CCM
  o Charge RN of unit
  o Inform Hospital Police of the referral to DSS and that the Safety Considerations Form has been completed. Hospital Police will send an officer to make a copy of the Safety Considerations Form. The original Safety Considerations Form should stay on the floor and should be affixed to the front of the patient’s chart.
  o The patient’s attending MD.
  o Beacon Child Protective Team

• A report must be made to law enforcement when the child has sustained serious injury. The report of this injury is made to the UNC Hospital Police.

• Hold the child or admit them to the hospital if there are any safety concerns until a child protective services worker responds and takes over this aspect of the management. NC General Statute 7B-308 states that any “physician or administrator of a hospital, clinic, or other medical facility to which a suspected abused juvenile is brought for medical diagnosis or treatment shall have the right, when authorized by the chief district court judge or his designee, to retain physical custody of the juvenile”

• Refer to UNC policy Suspected Child Abuse, Neglect, or Dependency, Policy Number ADMIN 0175 for further clarification/information.

STILL HAVE QUESTIONS?
• Refer to the resource manuals on the desk in room 47-C
• Refer to policies ADMIN 0175, NURS 0448
• Call the SANE Resource RN Koren (Kory) Garrity @ 919-593-4246. Please call twice, back to back, if first call is not answered.