

Recommended Guidelines

Sexual Assault Emergency Medical Evaluation Washington State

**Child 12 Years and Younger
2017**

The following is a guideline for conducting the medical-legal examination and collecting forensic evidence for children or all genders 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.”

Critical changes from 2012 Guidelines:

- The evidence collection window for pre-pubertal children has changed from **72 hours to 120 hours**. The evidence collection window for post-pubertal children remains **120 hours**.
- We have added detailed information regarding specific unique pediatric populations
- Expanded STI testing per CDC guidelines are clearly outlined for each infection including all sites and types of cultures needed to be obtained
- Cefixime is no longer considered effective treatment for Gonorrhea and should not be used.
- New Addenda:
 - Customizing a community pediatric exam protocol
 - Sample discharge instructions
 - Illustrations of exam positions and techniques
 - Post assault medication recommendations
 - Photography overview and tips
 - Sample trafficked victims charting aid
 - Sexual Identity terms
 - Sexually Transmitted Infections guidelines
 - Sexual Maturation stages
 - Strangulation assessment card and checklist
 - STI testing template

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.

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General



The medical exam is done for the benefit of the patient

Coordinated Response

Understand that the purpose of the exam is to address patients' health care needs and collect evidence when appropriate for potential use within the criminal justice system.

Victim-Centered Care

Recommendations at a glance for health care providers and other responders to facilitate victim-centered care during the exam process:

Social/Psychological

- Work as part of a multidisciplinary team to respond to child sexual abuse
- Communicate with children in a child-focused, victim-centered, and trauma-informed manner
- Provide ethical, compassionate, and objective health care
- Ensure children's immediate safety issues are addressed
- Recognize the impact that sexual abuse can have on children's health and wellbeing
- Ensure the needs of children and caregivers for support and crisis intervention are addressed
- Recognize the examination is an opportunity to facilitate healing by treating children holistically, taking into consideration the unique needs of each child and family unit

Medical

- Conduct a physical and anogenital examination and document exam findings (written and photo documentation)
- Screen for and treat STDs, including HIV, as applicable
- Refer children for post-exam care and services and caregivers for supportive services

Forensic and legal

- Collect forensic evidence, preserve evidence integrity and maintain chain of custody, transfer to law enforcement.
- Testify in court if needed

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

Child sexual abuse

Background

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. The medical provider should always consider differential diagnosis and alternative explanations for physical signs and symptoms. The outcome of any case is not possible to tell from the initial evaluation.

Sexual abuse of children is usually not physically violent. In the large majority of children, the physical exam is normal. However, a normal or non-specific exam does not rule out sexual abuse. It is important to note that:

- 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.
- Children often report weeks or months after the abuse event.
- Physical injuries to the genital or anal regions usually heal within a few days.

Second Opinion/Expert Consultation Secondary Review

Obtaining a second opinion is one aspect of the overall care of the patient. An examiner may reach out to an expert to obtain another opinion or confirm findings in any case of confirmed injury, high profile (i.e. abduction, large group, uncertain findings, or positive STI). The consulted expert reviews the medical report and photo-documentation and subsequently, should ideally provide formal written documentation of her/his review and conclusions. If a formal second opinion report is generated, then include the report in the patient’s medical record, which will be released for legal proceedings upon request. Local protocols should be clear in what situations a second opinion may be helpful and the process for obtaining one, and clarify how a second opinion and formal report differs from a program specific clinical peer review.

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 120 hours after an assault. 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.

Types of Exams

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. The type of exam will vary according to patient needs, the medical setting, and the expertise of the examiner.

Screening exam

Children are often brought to an emergency department or general medical provider because of parental concern of sexual abuse. The screening exam 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 of 120 hours.
- A comprehensive exam if outside the forensic time frame.

Acute exam

An acute exam includes a clarification of the history from the adults and may include history from the child. This exam is not intended to determine if abuse has ever occurred. It includes a complete exam for acute injury (bruises, abrasions, lacerations), and forensic collection and labs when appropriate. It is indicated when there has been a clear report or when the child has been in the presence of the alleged offender within the prior 120 hours.

Additional reasons for an acute sexual assault exam, even beyond 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

The 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.

Triage

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, a witness to the abuse, or if there are concerning symptoms (i.e. genital discomfort, bleeding, discharge, positive STI) an 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 time the patient was in the presence of the person of concern?

- 120 hours is the time frame for evidence collection for children and adolescents.
- Within this time frame, 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. If the incident was abusive or coercive in nature, then a CPS report must be made.

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.



The primary care provider may request consult with a child abuse specialist.

- A young child has made vague statements which might have a variety of interpretations.

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.

Note: Recognize that in these cases physical findings are even rarer 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 phone interpreters are acceptable
- Patients may be embarrassed to ask for an interpreter, so always assess if an interpreter is needed, even if patient states initially they do not need one.

Consent for Care for Minors

In general the parent or legal guardian must consent for care for patients less than 18 years of age. If a child is brought in for care by someone other than the parent or legal guardian, 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:

1. Medical provider confers with CPS regarding circumstances.
2. CPS notifies police to take the child into protective custody.
3. Police take the child into emergency protective custody.
4. CPS authorizes medical exam.
5. 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.

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](#). 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. CPS must be informed if there is suspicion that a caregiver or parent may have abused a child, or if there is

Note:

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.

concern about safety in the home. To make a CPS report in Washington State, call intake: 1-866-363-4276. See [CPS Reporting](#) for further information. In Washington State, CPS and police share information regarding child abuse reports.

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. Police should be informed as soon as possible if forensic evidence is collected.

Because the concern is regarding a criminal event, parents or guardians should be informed about the 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 if the following age differences apply:

Age of younger child	Age of older child
Less than 12	24 months or more months older
12 or 13 years	36 months or more older
14 or 15 years	48 months or more older

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

Confidentiality

No 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. They 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.

Medical and Forensic History

Medical history from the parent, guardian, or law enforcement

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. Also obtain and document information regarding the assault event in order to provide appropriate medical care and evidence collection.

What to 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 overhear 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/vulvar, penile or anal contact.
- Saliva or semen contact to skin and where.
- Whether or not 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.
- Has child 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 including CPS or police report, communication with reported offender, statements to their child.

Past medical history

- Developmental status, including communication delays, learning disabilities, special education.
- Age at menarche, or if pre-menarchal.
- Active and significant past medical problems.
- History of genital surgery, including urinary catheterizations or trauma.
- Current and recent medications, including antibiotics.
- Allergies to medications

Review of systems

- Special attention to GU or possible trauma related symptoms: vaginal, penile or rectal discomfort, dysuria, vaginal, penile or rectal discharge or bleeding, or bruising. Assess typical toileting patterns including history of constipation, enuresis or encopresis.
- Emotional symptoms: depression, anxiety, or behavior problems.

Social history

- Household composition: who lives in the home (including all homes child in which child resides).
- Other caregivers for child or households attended.
- Other children who may be at risk.

Note: Caution should be exercised when asking or requesting parent's own history of child abuse or neglect for reasons of confidentiality. It should not be part of standard history taking.

- Review of systems, with attention to trauma related symptoms: pain, limitation of motion, nausea or vomiting, loss of consciousness, skin symptoms, bleeding, dysuria, rectal discomfort
- Psychiatric history, including developmental delays, prior trauma, etc.

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. The medical provider does not need to obtain all the details of the event.

What to Document

- Persons present during conversation with child
- Demeanor of child
- Near-verbatim documentation of questions asked and child's answers (not paraphrased)

Interviewing the Child

Help 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?"). Avoid yes or no questions and multiple choice questions. 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.

- 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.
- 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 ...")

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

Forensic medical exam for pediatrics

General

The exam should never be painful. The exam should be done in a manner that is least disturbing to the child. 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.

The order of exam and evidence collection can vary; it is usually best to begin with less sensitive areas (hands and face).

Injury findings (bruises, abrasions, lacerations) should be noted in writing as well as photo-documented. Use a Bodygram (Traumagram). 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 generally contraindicated in pediatric sexual assault exams. These are rarely medical emergencies and exams requiring anesthesia are typically reserved for unique circumstances.

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, and do not forcibly restrain the child for the exam. Also:

- Use drapes to protect privacy, if the child wishes.
- Position the parent near the child's head and 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.
- 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 View master, TV, cellphone game, or other visual distraction.

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 underwear, is the most important source of DNA.
- Underwear 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 a genital examination may be happy to trade their underwear 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

Sedated exams are only indicated in rare and specific circumstances. A sedated exam would be indicated for:

- Retained foreign body
- Continued vaginal bleeding
- Significant physical abuse
- Clear need for forensic collection in child with developmental delays

Medical Exam/Assessment For Pediatrics

A head to toe exam is should be performed on all patients, with genital exam being the last portion. Injuries (bruises, abrasions, lacerations) should be noted in writing, as well as on the traumagram and photographed with patient consent.

- Forensic exam documentation would not be considered complete without a documented traumagram.
- Because a patient may not recall or may be embarrassed to report all aspects of the assault, the exam should be complete and evidence routinely collected from all orifices (mouth, vagina, penis and rectum) regardless of report.
- The patient may decline any aspects of the exam or evidence collection.

A complete physical exam should include the following:

General Exam:

****Remember the rule of TEN-4:** Injuries to children on the trunk, ears and neck or in any child less than 4 months of age are highly concerning for abusive injuries. **

- **Skin:** Examine for tenderness, bruises, abrasions, lacerations and bite marks. Injury documentation should include description of type, size, color, pattern and associated pain. As much as possible, each injury should be individually documented.
- **HEENT:** (Head, Ears, Eyes, Nose, Throat)
 - Head: Palpate scalp for tenderness or swelling, assess for loss of hair and sponginess
 - Ears: Assess for blood in canals, bruising on pinna or behind ear
 - Eyes: Assess for conjunctival hemorrhage and petechiae, including assessment of sclera and inner eye lids, periorbital petechiae and bruising. In cases involving intoxication or drugging, assess pupil size and reactivity. Document reports of vision changes as related to injuries
 - Nose: Document any injuries including noted fractures

- **Throat/Mouth:** Examine soft and hard palate for petechiae or exudate. Assess inner lips and tongue for bruising, lacerations, bites or torn frenulum. Note broken or loose teeth.
- **Neck:** Examine for bruises, suction injuries or ligature marks. Assess ROM and tenderness. Note if voice is hoarse.
- **Chest:** Auscultate lung sounds, examine for tenderness, bruises or bite marks.
- **Heart:** Auscultate heart sounds
- **Abdomen:** Palpate for tenderness and masses. Auscultate for bowel tones.
- **Extremities:** Note bruises, ligature marks, abrasions, pattern injuries. Evaluate for pain, tenderness, ROM of arms and legs and any obvious deformities
- **Neuro/Mental:** Assess developmental level and orientation to person, place and time.

Genital Exam:

The purpose of the genital exam may vary depending on the experience level of the provider. For the acute sexual assault exam of any child, the genital exam purpose is to assess for any obvious acute injury. There are generally only three findings that may be associated with the acute exam. These would be:

- Normal genital exam with no acute injuries
- Acute injuries, described by type, size, location
- Abnormal or atypical findings with clear written description of what is seen and location.

The purpose of the acute sexual assault exam of a child is not to make a statement as to the likelihood that any findings are related to sexual assault. There can be more than one reason for any genital finding and the consequences of confirmed sexual abuse in children can be significant. The finding of sexual abuse should only be made with expert consultation.

Girls: Exam is most often performed in frog leg position or with feet in stirrups in dorsal lithotomy position.

Assess the **Vulva, Posterior Fourchette and Fossa, Hymen, Perineum and Anus**. Using the clock as reference, note the location of any obvious lacerations, abrasions, swelling or contusions including documentation of any tenderness. Redness or other discoloration or atypical findings should be clearly described as to color, size and location on the body.

Internal vaginal exam is contraindicated in pre-pubertal exams and should only be done in very limitations situations (i.e. retained foreign body, significant vaginal bleeding, and significant physical abuse trauma) under sedation. Sedation is not needed for routine sexual assault exams of children.

Boys: Exam is most often performed with child lying on their back or side.

Assess the **penis** (including foreskin, corona, glans and shaft), **scrotum** and **anus**. Note any obvious abrasions, lacerations, contusions, or swelling including documentation of any tenderness. Redness, discoloration or other atypical findings should be clearly described as to color, size and location on the body.

For boys, the clock can be used for the anal exam but is not used in documenting the penile or scrotal exam.

Forensic Evidence Collection

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 or face). Injuries (bruises, abrasions, lacerations) should be noted in writing as well as photo-documented.

In general, forensic evidence collection in all children presenting for a concern of sexual assault should include the following swabs: oral, finger tip, perineal vulvar, scrotal, vaginal, penile, and anal.

Collection of skin swabs, debris on skin, trace debris, pubic hair combing and urine or blood for toxicology should be considered based on report and circumstances. Typically, collection of reference blood is deferred in children.

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, penis and rectum) is routine.

Basics of evidence collection:

- 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.
 1. Moisten one swab with sterile water (supplied in kit). Swab area lightly.
 2. Repeat with dry swab.
 3. Label swabs and diagram on envelope to indicate sites (SS #1, SS#2, etc)

Medical Exam and Evidence Collection Steps

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

	Exam	Evidence
Urine pregnancy test	For all females who are pubertal, Tanner 3 or above, or over 10 years of age	Urine collection for pregnancy test (this is as sensitive as current blood tests)
Toxicology	If patient appears impaired, or history of alcohol ingestion within prior 12 hours	Obtain stat blood alcohol and urine toxicology through hospital lab
Forensic toxicology	Routine If concern for drugging or substance use was within prior 24 hours, collect	<u>Urine for forensic toxicology</u> (routine) If < 24 hours Blood: 2 grey-top blood tubes

Mouth	<p>urine and blood for forensic toxicology</p> <p>If >24 hours, collect urine only</p>	<p>+</p> <p>Urine: 30 ml urine</p> <p>If >24 hours: Urine: 30 ml</p> <p>Collect urine in standard specimen cup and then transfer urine to state toxicology leak-proof plastic cup or 2 red top tubes. Place in biohazard bag</p> <p>Refrigerate or freeze or transfer to law enforcement within 3 hours.</p> <p>Do NOT freeze glass tubes.</p> <p>Do NOT package in kit. Transfer separately to law enforcement</p>
	<p>Examine soft and hard palate, inner lips and tongue for bruising or lacerations</p> <p>Note missing teeth</p>	<p><u>Oral swabs</u></p> <p>Use 4 cotton swabs total. Do not moisten</p> <p>Using 2 swabs at a time, swab around gingival border, at margins of teeth, buccal and lingual surfaces</p> <p>Repeat with remaining 2 swabs</p>
Hands	<p>Examine for nails broken at assault, wounds on hands</p> <p>Examine for foreign debris</p>	<p><u>Fingertip swabs</u></p> <p>Use 4 swabs total - 2 swabs for each hand</p> <p>With 1 moistened swab, swab all 5 fingertips of one hand, concentrating on area under nails</p> <p>Repeat with 1 dry swab on same hand</p> <p>Repeat process on other hand</p> <p>Both swabs from one hand may be packaged in same box</p>
Blood specimen on filter paper	<p>To obtain patient DNA</p> <p>Do not obtain for young children unless drawing blood for other tests</p>	<p><u>Blood reference sample</u></p> <p>Use lancet from kit, or small needle and syringe</p> <p>May obtain at the same time in same syringe as other labs</p> <p>Place blood on designated filter (FTA) paper, fill at least 2 circles</p> <p>(This step may be more traumatic for young children than any other part of the evaluation. DNA reference sample can be obtained later)</p>
Trace Debris	<p>If patient has not bathed or changed clothes, especially when assault was out of doors</p>	<p><u>Trace debris</u></p> <p>Place clean bed sheet on floor</p> <p>Place paper from "Trace Debris" envelope on</p>

Clothing		<p>top of sheet</p> <p>Have patient undress while standing on paper</p> <p>Fold paper to retain debris</p> <p>Place in envelope, seal, sign and date over tape</p> <p>Have patient dress in examination gown</p>
	Examine clothing for rips, stains. Ask if these occurred during abuse/assault. Document on report	<p>Collect clothing worn at time of abuse/assault</p> <p>Place each article of clothing in a separate brown paper bag</p> <p>Fold top of bag over one time. Place and sign evidence seal across the folded area of bag.</p> <p>Seal paper bag with clear packing tape over the evidence seal.</p> <p>Place clothing bag label on bag and document what type of clothing is included in the bag (i.e. shirt, pants, etc).</p>
Underpants		<p>Collect underpants, even if changed after assault</p>
Diapers		<p>Package in a small paper bag</p> <p>Seal, label, place in the Evidence Kit</p> <p>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</p>
Head and neck	<p>Scalp: Palpate for tenderness or swelling</p> <p>Ears: blood in canals, bruising on pinna or behind ear</p> <p>Neck: tenderness or limitation of motion</p> <p>Eyes: Conjunctival hemorrhage, sclera and inner eyelids) Periorbital petechiae</p>	<p><u>Skin swabs</u></p> <p>Ask patient if areas may have assailant saliva or semen deposition</p> <p>Swab all suspect areas, as well as visible bite marks or suction bruises, and dried secretions on skin</p> <p>For areas of bruising concerning for grip marks, consider swabbing for potential touch DNA</p>
Skin Chest/ Breasts Abdomen Extremities	<p>Examine for tenderness, bruises, bite marks</p> <p>Palpate for tenderness,</p>	<p><u>Skin swabs</u></p> <p>Swab areas where patient reports saliva, ejaculation, grip marks or where dried</p>

	<p>masses</p> <p>Note bruises, ligature marks, lacerations, abrasions</p> <p>Evaluate pain, tenderness, range of motion arms and legs</p>	<p>secretions are seen</p> <p>Obtain swabs even if patient bathed after event, since bathing may be incomplete</p> <p>Use 2 swabs total for each site</p> <p>Moisten 1 swab with 1 drop of water</p> <p>Swab area of suspected foreign secretions</p> <p>Repeat with second, dry swab</p> <p>Repeat 2 swab wet/dry technique for each suspect area</p> <p>Indicate on envelope if saliva, semen or touch DNA is suspected by patient report</p>
Genital exam - Female	<p>Examine in frog leg or dorsal lithotomy</p> <p>Examine inner thighs, labia majora, perineum.</p> <p>Document tenderness, bruises, abrasions, lacerations, Examine vulva and perineum</p> <p><i>Speculum exam is rarely needed for premenarchal girls. If needed for active bleeding or foreign bod removal, this must be done under general anesthesia</i></p> <p>Examine inner labia and vaginal introitus (hymen)</p> <p>Using labial separation and then labial traction, examine labia majora, labia minora, introitus, posterior fourchette, fossa navicularis</p>	<p><u>Pubic hair combing</u> if patient has pubic hair</p> <p>With patient in dorsal lithotomy, place clean paper under buttocks</p> <p>Using supplied comb, comb downward to collect loose hairs</p> <p>Fold paper to retain hairs, and place in envelope</p> <p>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</p> <p>If matted pubic hair is noted, use clean scissors to clip hair</p> <p><u>Vulvar/ perineal swabs</u></p> <p>Use 4 cotton swabs total</p> <p>Moisten 2 swabs with 1 drop of water on each</p> <p>Swab external genital folds and perineum</p> <p>Repeat with 2 dry swabs</p> <p><u>Vaginal swabs</u></p> <p>Use 4 cotton swabs total</p> <p>Using two moistened swabs at a time, swab inner labia bilaterally, avoid contact with thehymen</p> <p>Package in “vaginal swabs” envelope, specify site of collection in chart and on envelope</p>
Retained foreign bodies		Place in urine specimen cup

<p>Toluidine blue dye</p> <p>Bimanual exam</p>	<p>Not indicated for children or young teens</p> <p>Not indicated for children or young teens</p>	<p>Place cup in biohazard bag and label</p> <p>Transfer to law enforcement within 3 hours or freeze for later transfer</p>
<p>Genital exam – Male</p>	<p>Examine inner thighs, all sides of penile shaft, corona, foreskin, glans penis, scrotum, and perineum</p> <p>Document abrasions, bruises, lacerations, erythema, and inflammation</p>	<p><u>Scrotal/perineal swabs</u></p> <p>Use 4 cotton swabs. Moisten 2 with 1 drop of water on each</p> <p>Swab all aspects of the scrotum and perineum</p> <p>Repeat with 2 dry swabs</p> <p>After drying, package in swab boxes labeled “scrotal/perineal”</p> <p>Place in the “perineal/vulvar” envelope. Mark “scrotum/perineum” on back of envelope.</p> <p><u>Penile swabs</u></p> <p>Use 4 cotton swabs. Moisten 2 with 1 drop of water on each</p> <p>Swab penis: anterior, lateral, posterior and glans penis and under foreskin with moistened swabs</p> <p>Repeat with 2 dry swabs</p> <p>After drying, package in swab boxes marked “penile”.</p> <p>Place in “vaginal/endocervical” envelope. Mark “Penile swabs” on back of envelope.</p> <p>Seal envelope with evidence label and complete information.</p>

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

Evidence Packaging

Specifics of evidence packaging may be obtained from "[Sexual Assault Evidence Packaging Handbook](#)" for Washington State.

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.

Swabs

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" or "touch DNA" if known.

Drying

Be sure to maintain chain of custody while 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.

- ▶ Swabs may be locked in room, cabinet or drying box to dry
- ▶ Do not use heat or fan to dry swabs
- ▶ If Plexiglas 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 20% bleach or hospital approved disinfectant

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)

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 are present, hand drawing as well as photography is highly recommended for documentation. A standard protocol should be in place for taking photos, storage, and transfer.

Photography with digital or video camera

- Each camera type has advantages and limitations.
- 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
- Each institution should take appropriate steps to maintain the privacy and dignity of the patient in photos
- 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.

Technique

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
- First photo is of patient identification label
- One photo should include patient face
- Photograph each injury site 3 times
 1. At least 3 feet away, to show the injury in context (on which bodypart)
 2. Close up
 3. 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
- Hospital personnel may either take the photos or assist law enforcement in obtaining photos

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-colposcopy, 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

Storage

- Photos are considered 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) on a secure server
- Prosecution of child sexual abuse cases can occur many years after the initial exam. Photos should be retained through the statute of limitations.



Provide formal tracking of copies, release dates, and person responsible for releasing and receiving photos.

Release

- Follow HIPPA compliance policies for release of all records including photos
- Photos may be released to law enforcement with proper authorization EXCEPT colposcopy photos or genital/anal photos. Because of the extremely confidential nature of colposcopy photos, these are released only in response to a subpoena and then are released directly to the medical expert who will review the photos.

Lab tests

Pregnancy Test

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

General

STIs 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 STI should prompt testing or evaluation for other STIs.

STI testing is recommended under the following conditions:

- Child experienced penetration or there is evidence of recently healed penetrative injury to genitals, anus, or oropharynx
- Child has been abused by a stranger
- Child has been abused by a perpetrator known to be infected with a STI or at high risk for STIs (e.g., intravenous drug abusers, men who have sex with men, people with multiple sex partners, and those with histories of STIs)
- Child has a sibling or other relative or person in the household with a STI
- Child lives in an area with a high rate of STIs in the community
- Child has signs or symptoms of STIs (e.g., vaginal discharge or pain, genital itching or odor, urinary symptoms, and genital lesions or ulcers)
- Child has already been diagnosed with one STI
- Child or caregiver requests STI testing

References

[Adams, J, Kellogg, N, Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused. Journal of Ped and Adolescent Gynecology: 2016, vol. 29, Issue 2: 81-87](#)

[Christian, C, American Academy of Pediatrics Committee on Child Abuse and Neglect. The evaluation of suspected child physical abuse. Pediatrics April 2015](#)

[CDC Sexually Transmitted Disease Guidelines 2015](#)

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 can 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 extra genital gonorrhea or chlamydia if internal validation of the method by a verification study is performed.

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.
- Perinatal transmission of 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 can 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 may be a symptom.

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 1 or 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 can be symptoms. 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 children, 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 differentiate between molluscum, skin tags, psuedoverruca, and condylomalata.
- Vertical transmission is thought to 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 2015](#)

Non-Sexually Transmitted Diseases

Vulvovaginitis

Vulvovaginitis is common in pre-pubertal girls, and is usually due to irritation or infection with non-sexually transmitted organisms. 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.

Medical Treatment

Emergency Contraception

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.

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.

- See [RCW 70.41.350](#) and [WAC 246.320.286](#)
- See [Post Assault Medications](#)

STI Post-Exposure Prophylaxis

Children should not be treated for gonorrhea or chlamydia before confirmatory tests are performed.

- See [Post Assault Medications](#)

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 Post Exposure Prophylaxis Guideline](#)

Unique Populations¹

Cultural Groups

Culture can influence beliefs about sexual assault, its victims and offenders, as well as healthcare practitioners. It can affect health care beliefs and practices related to the assault and medical treatment outcomes, and to emotional healing from an assault. In addition, it can impact beliefs and practices regarding justice in the aftermath of a sexual assault, the response of the criminal justice system, and the willingness of victims to be involved in the system.

- Some victims may be apprehensive about interacting with responders from ethnic and racial backgrounds different from their own.
- Be aware that cultural beliefs may preclude a member of the opposite sex from being present when victims disclose.
- Be aware that beliefs about women, men, sexuality, sexual orientation, gender identity or expression, race, ethnicity, and religion may vary greatly among victims of different cultural backgrounds. Also, understand that what helps one victim deal with a traumatic situation like sexual assault may not be the same for another victim.
- Help victims obtain culturally specific assistance and/or provide referrals where they exist.

Disabled

Understand that victims with disabilities may have physical, sensory, cognitive, developmental, or mental health disabilities, or a combination of disabilities. Make every effort to recognize issues that arise for victims with disabilities (both in general and in relation to their specific disability) and provide reasonable accommodations when working with them.

- People with disabilities are often victimized repeatedly by the same offender. Caretakers, family members, or friends may be responsible for the sexual assault.
- Speak directly to victims with disabilities, even when interpreters, intermediaries, or guardians are present.
- Recognize that individuals may have some degree of cognitive disability: mental retardation, traumatic brain injury, neurodegenerative conditions, or stroke.
- Assess a victim's level of ability and need for assistance during the exam process. Ask for permission before proceeding in an exam (or touch them, handle a mobility or communication device, or touch a service animal).
- Keep in mind that victims with disabilities may be reluctant to report the crime or consent to the exam for a variety of reasons, including fear of not being believed, fear of getting in trouble, and fear of losing their independence. The perpetrator may also be their caregiver and the only person they rely on for daily living assistance.

¹ This section is adapted from the U.S. Department of Justice's "A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents, Second Addition," April 2013, 32-29.

- Recognize that the exam may take longer to perform with victims with disabilities. Avoid rushing through the exam—such action not only may distress victims, it can lead to missed evidence and information.
- Recognize that it may be the first time victims with disabilities have an internal exam. The procedure should be explained in detail in language they can understand. They may have limited knowledge of reproductive health issues and not be able to describe what happened to them. They may not know how they feel about the incident or even identify that a crime was committed against them.

Male Victims

Young men and boys can be victims of sexual assault by women or by men.

- Help male victims understand that male sexual assault is not uncommon and that the assault is not their fault. Many male victims focus on the sexual aspect of the assault and overlook other elements such as coercion, power differences, and emotional abuse. Broadening their understanding of sexual assault may reduce their self-blame.
- Because some male victims may fear public disclosure of the assault and the stigma associated with male sexual victimization, emphasis may need to be placed on the scope of confidentiality of patient information during the exam process.
- Offer male victims assistance in considering how friends and family members will react to the fact that they were sexually assaulted (e.g., by a male offender or a female offender).
- Male victims may be less likely than females to seek and receive support from family members and friends, as well as from advocacy and counseling services.

Military

Child physical and sexual abuse does not allow for the military option of restricted reporting. These are all mandatory reports to CPS and the legal jurisdiction which may be the military police or local law enforcement.

All families with children who are victims of physical or sexual abuse should be referred to the military family advocacy program for their base or installation. The Family Advocacy program will open a case (not an investigation) and will develop a plan of treatment/care for all members of the family including victim, offender and support people. This occurs simultaneously with the legal investigation of the allegations.

Exam sites that provide exams for military installations are encouraged to draft Memoranda of Understanding to address such issues as confidentiality and storage of evidence.

Multiple Victims

Victims may reside in group homes, daycares, schools, summers camps, sports teams, or be inpatient in hospitals. Examination and evidence collection can be done even if outside of the standard time frame, as mobility and cognitive impairments may be present.

Appropriate triage and planning is essential to a patient-centered, coordinated response.

Considerations should include:

- Timing of exams
- Transportation to exams
- Location of exam (clinic vs ED)
- Collaboration/coordination between multiple healthcare facilities to provide exams for multiple victims
- Which patients actually need exams (anyone with possible exposure to offender should have an exam)
- Multiple examiners may be needed to prevent possible cross contamination of evidence

Exam/examiner considerations should include:

- Multiple victims needing exams at the same time
- Need for multidisciplinary collaboration (health care, social work, APS, facility staff)
- Availability of multiple facilities and multiple examiners to care for victims
- Availability of appropriate, private exam location/facility
- Ability to ensure no cross-contamination of evidence
- Discharge planning which may include possible need for relocation/change in housing
- Inclusion of support person for exam
- Access to medical records from home or facility
- Past medical history including records from facility
- Fear, anger or depression can be common responses in these victims. Fear of losing independence as a result of family members learning about the sexual assault can be a strong deterrent to reporting.
- Recognition by health care professionals that the offender may be a family member, friend or caregiver is important.

Native Americans

American Indian and Alaska Native victims may have unique cultural or language needs, whether they are assaulted in Indian Country or an Alaska Native village or in an urban area.

- Recognize that Indian tribes may have their own laws and regulations, as well as their own police, prosecutors, advocates, courts, and service providers to address sexual assault.
- As in many cultures, American Indian/Alaska Native women are of central and primary importance to the family and the community. Be mindful that sexual violence against a Native woman may be seen as an assault on both the individual and her community.
- Be mindful of historical trauma. Some victims may be slow to engage with non-natives.

Repeat Exams/Custody Issues

While not common, there are times when the sexual assault exam is used as a tool in custody disputes. If parents are repeatedly bringing their children in for multiple sexual assault exams with reports of the same offender, programs are encouraged to strongly consider limiting exams.

Repeated sexual assault interviews and exams of children are a form of medical child abuse and should be discouraged. It can be helpful to engage a multi-disciplinary team that includes medical, law enforcement, CPS and prosecutors to assess the family situation, the veracity of the reports and

the actual need for ongoing exams. The team can then put a care plan in place to offer a framework for care that all providers and team members can use going forward.

As in all sexual assault exams, the primary concern is for the well-being of the child, not to meet custody needs of the parent.

Sex Trafficked/Commercial Sexually Exploited Victims

Human trafficking is considered an especially egregious form of exploitation of vulnerable persons and an emerging health care priority. Victims of sex trafficking can come from all countries and walks of life, though the majority of victims are women and girls. See [Trafficking Questionnaire and Charting](#) for a sample charting aid.

- Key factors for sex trafficking include young age, history of abuse, poverty, lack of education, conflict with family of origin, lack of economic opportunity
- Traffickers may include females who are respected in communities, males who present as “boyfriends” or even family members.
- It is important for providers to recognize the varied experiences and reactions of victims and to demonstrate consistent, culturally aware trauma-informed care when working with sexually trafficked persons.
- Disclosures can be both emotionally difficult and potentially dangerous for the victim.
- Victims may not disclose even in a supportive medical environment due to fear for safety, loyalty to trafficker, or lack of understanding of their situation.

Red flags for trafficking include:

- Recurrent STI’s
- Multiple or frequent pregnancies
- Frequent or forced abortions
- Delayed presentation for medical care
- Companion who speaks for the patient and controls the encounter and refuses to leave
- Discrepancy between stated history and clinical presentation or pattern of injury
- Tattoos or other marks that may indicate “ownership” by another person

Trafficking of Children/Adolescents

- Presentation to health care with non-guardian or unrelated adults
- Access to material possessions outside their financial means
- Over-familiarity with sexual terms and practices
- Excessive number of sexual partners
- School truancy
- Fearful attachment to cell phone (often used by the trafficker as a monitoring or tracking device)

Providers should:

- Provide culturally sensitive, resilience-oriented trauma informed care to all patients
- Partner with advocates, social service providers and case managers to ensure all needs are met
- Educate self on dynamics of trafficking and resources within each community

Resources

National Human Trafficking Resource Hotline: 1-888-373-7888

Human Trafficking Guidebook on Identification, Assessment and Response in the Health Care Setting

[Massachusetts Medical Society: Human Trafficking](#)

Sexual Minority Patients (LGBTQ)

For a glossary of terms, see [Sexual Identity Terms](#).

Things to note for sexual minority patients:

- Always refer to victims by their preferred name and pronoun, even when speaking to others. If unsure of what to call the person or what pronoun to use, ask the patient.
- Treat the knowledge that the person is LGBT as protected medical information subject to all confidentiality and privacy rules. Be aware that companions of LGBT victims may not know their gender identity or sexual orientation.

Victims Who Are Transgender or Gender Non-Conforming

- Understand that transgender people have typically been subject to others' curiosity, prejudice, and violence. Transgender victims may be reluctant to report the crime or consent to the exam for fear of being exposed to inappropriate questions or abuse.
- If the victim does consent to an exam, be especially careful to explain what you want to do and why before each step, and respect their right to decline any part of the exam.
- Be aware that transgender individuals may have increased shame or dissociation from their body. Some use nonstandard labels for body parts, and others are unable to discuss sex-related body parts at all.
- Vaginas that have been exposed to testosterone or created surgically are more fragile than vaginas of most non-transgender women and may sustain more damage in an assault.
- Transgender male individuals who still have ovaries and a uterus can become pregnant even when they were using testosterone and/or had not been menstruating.

Advocacy And Support

Many hospitals have a partnership with the local Child Advocacy Center (CAC). If this partnership is not in place, provide information regarding local Child Advocacy Centers before discharge.

- This partnership may include calling an advocate before the patient arrives. The advocate can provide support and resources. In some communities, an advocate is available for the medical exam.
- If a medical advocate is available, it is preferable to call them as soon as the patient presents. As long as personal identifiers are not provided initially, it is not a HIPPA violation to make this call.
- The patient has the choice to have an advocate or support person present at the medical facility [RCW 70.125.060](#). In the absence of an advocate, a social worker, sexual assault nurse

examiner, or healthcare provider can stand in as a support person. The patient and provider together decide who will be present during the examination.

- Medical information cannot be shared without the patient's authorization (except for minors). With patient's written authorization, medical information can be shared with the CAC for follow-up and advocacy.

Authorization To Release Confidential Health Information

Protected health information includes:

- Personal Identifying Information
- Medical records
- Photographs obtained by medical personnel
- Any evidence, including clothing and evidence kit obtained in the hospital

These are protected health information and are subject to HIPAA regulations

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 in cases of suspected child physical or sexual abuse.

See [RCW 26.44.040](#)

Discharge

- Explain physical findings.
- Explain follow-up procedure for medical test results (who will contact the family).
- Discuss CPS report.
- Explain that if police report was made, a detective may be contacting 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

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

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, flashbacks)
- Concerns for safety and legal issues.
- Contact with police and CPS.
- Concerns regarding STIs 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:

Depending on risks and patient concerns:

- Pregnancy test
- Test for gonorrhea and chlamydia if single dose prophylaxis was not given at initial evaluation at 2-3 weeks
- Syphilis test, Hepatitis B and C at 3 months
- HIV testing at 1 month, and 3 months
- Hepatitis B vaccine. If series initiated at acute examination, continue to complete the 3 vaccine series
- Consider offering, discussing, referring for HPV vaccine series (Gardasil)
- Any child with a positive STI should be referred to a sexual assault medical specialist and be seen within two weeks. A CAC can refer to a medical specialist.

Assess social support (family, friends)

Refer for follow-up medical care, counseling and advocacy

Billing

By law, 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 (CVC). The victim is not required to make a police report and does not need a “positive finding” of sexual assault for CVC to cover the initial exam.

Application

- The information for completing the online CVC application should be given to the parent or patient. *Do not* submit an application for the ED visit. This is already covered without an application.
- CVC prefers that the application be completed after further medical or counseling care is obtained.



A patient does not have to complete the CVC application for the initial exam

Coverage and Billing

- Treatment, including antibiotics, emergency contraception, HEP B and tetanus vaccines, HIV prophylaxis, as well as all labs associated with the exam are covered by CVC.
 - Assessment and treatment of injury (e.g. broken arm caused by the assault) is billed to the patient or their insurance. If patient applies to Crime Victims Compensation and their claim is approved, CVC becomes the secondary payer for additional medical and counseling needs.
- Billing requires the use of specific local codes and completion of a SAFE form. See [CVC Information for Providers](#).

For further information, see [Washington State Crime Victim's Compensation](#). Phone: 800-762-3716.

Addenda

Customizing a Community Protocol

Communities starting from scratch in developing pediatric sexual abuse medical forensic exam protocols are encouraged to consider the recommendations in this national protocol in their entirety and tailor them to fit local needs, challenges, statutes, and policies.

Communities that have existing protocols can consider whether any of the protocol recommendations or the tasks below could improve their response to prepubescent child sexual abuse or address gaps in services or interventions.



Contact staff at kidsta.org for technical assistance to help communities address questions that arise during the process of developing, implementing, refining, and enhancing pediatric exam protocols.

Tasks to Customize a Community Pediatric Exam Protocol²

- Form a core planning team. This team should include representatives from core responding entities involved in the pediatric exam process in the community. Representatives should have authority to make policy decisions on behalf of their agencies. If there is already a multidisciplinary response team, it can serve as the core protocol planning team. Make sure your core team seeks input on exam process coordination issues from representatives from tribal lands or military installations within or neighboring the community, as well as institutions within the community that house prepubescent children or place them in housing.
- Seek input from other responders to child sexual abuse. In addition to other professionals directly involved in comprehensive response, organizations serving specific child populations in the community should also be involved. Their input regarding practices related to initial response and the exam process could be sought at least at two points. First, prior to protocol writing, solicit their thoughts about what is essential to include in the protocol and what areas of practice could be improved. Second, once the protocol is drafted, share it with them for their review and comment.
- Identify roles in planning. Early in the process, it is important to determine which entities and individuals will be responsible for coordinating overall protocol development planning and related research/information gathering, drafting the protocol, seeking approval for the protocol across entities, and periodically evaluating and updating the protocol.
- Assess needs. Before initiating policy changes, the planning team should assess the jurisdiction's current response to child sexual abuse, with a focus on the exam process. (Contact staff at kidsta.org to discuss strategies for community assessment related to improving local response to child sexual abuse specifically around the exam process)
- Devise an action plan and create/revise the protocol. The planning team can take what it learns through needs assessments and translate it into an action plan for improving the

² U.S. Department of Justice (DOJ). A National Protocol for Sexual Abuse Medical Forensic Examinations, Pediatric, April 2016. 213-14.

exam process via the protocol. The plan should identify the steps that need to happen to finalize the protocol, who is responsible for coordinating or carrying out each action, possible resources, desired outcomes, and how the effectiveness of the action will be evaluated. As far as the specifics of identifying practices to include in the protocol and protocol writing, the team should consider (Littel, Malefyt, & Walker, 1998): What process will be used to facilitate decision making on (1) protocol development or revision, (2) protocol drafting and review by partners in response to child sexual abuse, and (3) adoption of the protocol by individual agencies/facilities or the community? How will protocol compliance be monitored and what mechanisms will be employed to solve problems that arise? The planning team should review the national protocol to determine what it wants to adapt for its protocol. It must consider jurisdictional statutes and policies and how to address community-specific needs and challenges. The action plan can be revisited periodically to assess progress and evaluate outcomes. Distribute the protocol. The planning team should determine the most efficient method to disseminate the protocol to all professionals in the jurisdiction who are involved in the initial response to child sexual abuse and the exam process. The planning team needs an up-to-date contact list of these professionals, and it should agree upon a specific distribution plan. If electronic distribution is employed, make sure that professionals who do not have Internet access get a hard copy.

- Build the capacity of involved entities to implement the protocol. (See Littel, Malefyt, & Walker, 1998) A protocol's effectiveness depends on individual agencies/facilities having adequate resources (e.g., funding, personnel, child-friendly approach, multi-language capacity, equipment, supervision, training, professional development opportunities, and community partnerships) to carry out their responsibilities and coordinate efforts with other involved responders. Agencies/facilities can assist one another in building individual and collective capacity to respond to child sexual abuse and participate in coordinated interventions.
- Promote accountability. To help with validating the protocol as a legitimate tool and promoting resource allocation to implement the protocol, consider asking responding agencies/facilities to supplement the protocol with interagency agreements or memorandums of understanding. Using the protocol as a basis, these agreements can outline roles and articulate how responders should work together to coordinate response. These documents should be jointly developed, agreed upon, and signed by agency/facility policymakers. They can be revised and signed on a periodic basis to ensure all agency personnel involved in the response are aware of protocol changes and reaffirm agency/facility commitment to carrying out agreements. Role checklists and performance outcome measures related to protocol practices for all team members can also be useful.
- Promote training. Agency/facility-specific, multidisciplinary, and cross-trainings are crucial components of protocol implementation. Involved responders must be informed of any.

Discharge Instructions Sample

EMERGENCY DEPARTMENT DISCHARGE SUMMARY

INFORMATION FOR CHILDREN AND PARENTS

What Happens Next?

If a report was made to police or CPS you can expect a call from them within a few days. A counselor from our program will call you within several days to ask how you and your child are doing and offer help.

Here Are Some Things You Can Do For Your Child And Yourself:

- ◆ Talk with a friend, family member, or someone you trust about what has happened
- ◆ Read the handout “Taking Care of Your Child” which the social worker will give to you.
- ◆ Talk with a counselor from our program about your concerns and questions.
- ◆ Call **Intake** (206) 744-1600.

If you have a computer, there is more information on the website www.hcsats.org

Can My Child And I Talk To A Counselor?

HCSATS social workers provide support and assistance to families affected by sexual abuse or assault. They can provide trauma-focused counseling to help your child deal with the effects of sexual abuse as well as provide legal advocacy, information, and referrals. You can arrange this when you come in for your follow-up medical appointment, or you can call our office beforehand and ask for a counseling appointment as soon as possible. The initial counseling appointment is free.

What Is The Medical Specialty Appointment?

Sometimes an exam by a specialist is recommended. After reviewing the medical record, a specialist from the Center will decide if your child should be seen for a specialty medical exam. This exam is to see if there are any other signs of injury, as well as to review any medical questions you may have. We will arrange this appointment with you.

Where Is The Appointment?

Our clinic is in the Pat Steele Building, at 401 Broadway, two blocks away from the hospital. This is a quiet and comfortable clinic. Parking is available underneath the building or on the street. Enter the parking garage from Jefferson Street. **Parking will be paid for by HCSATS for your first appointment.** Metro bus 3 and 4 go from downtown to the clinic corner.

These Tests Were Done In The Emergency Department:

- Collection of legal evidence for testing: This evidence is transferred to the police. If a criminal case develops the detective may ask that these samples be processed. The results of these tests are not normally available to you, the doctor, or nurse. Please contact the detective if you have questions regarding these tests.

- Medical photos: If medical photos were taken, they will be reviewed by a specialist from HCSATS. The doctor or nurse practitioner can discuss these results with you at your follow-up appointment.

- Lab tests: We will call you if any of these tests are abnormal

The Following Medicines Were Prescribed:

The Following Agencies Were Notified, As Required By Law:

_____ Law Enforcement

_____ Child Protective Services

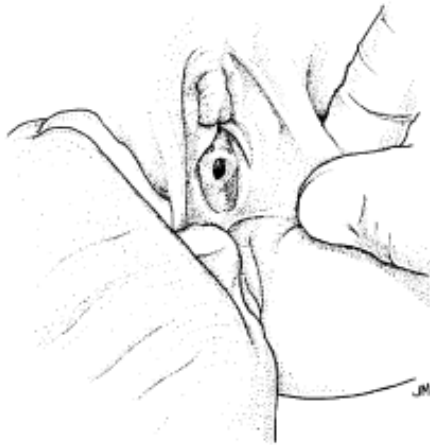
If your child is having any emergency problems related to the assault, call the Harborview Center for Sexual Assault and Traumatic Stress at **(206) 744-1600**. Nights and weekends you will be connected to the Harborview Emergency Department.

Date: _____

Clinician _____

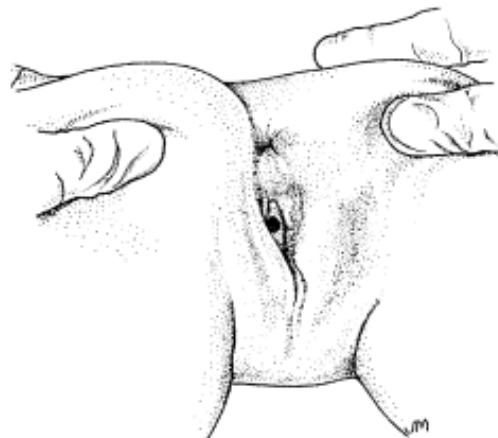
Illustrations of Exam Positions and Techniques

Supine Labial Separation



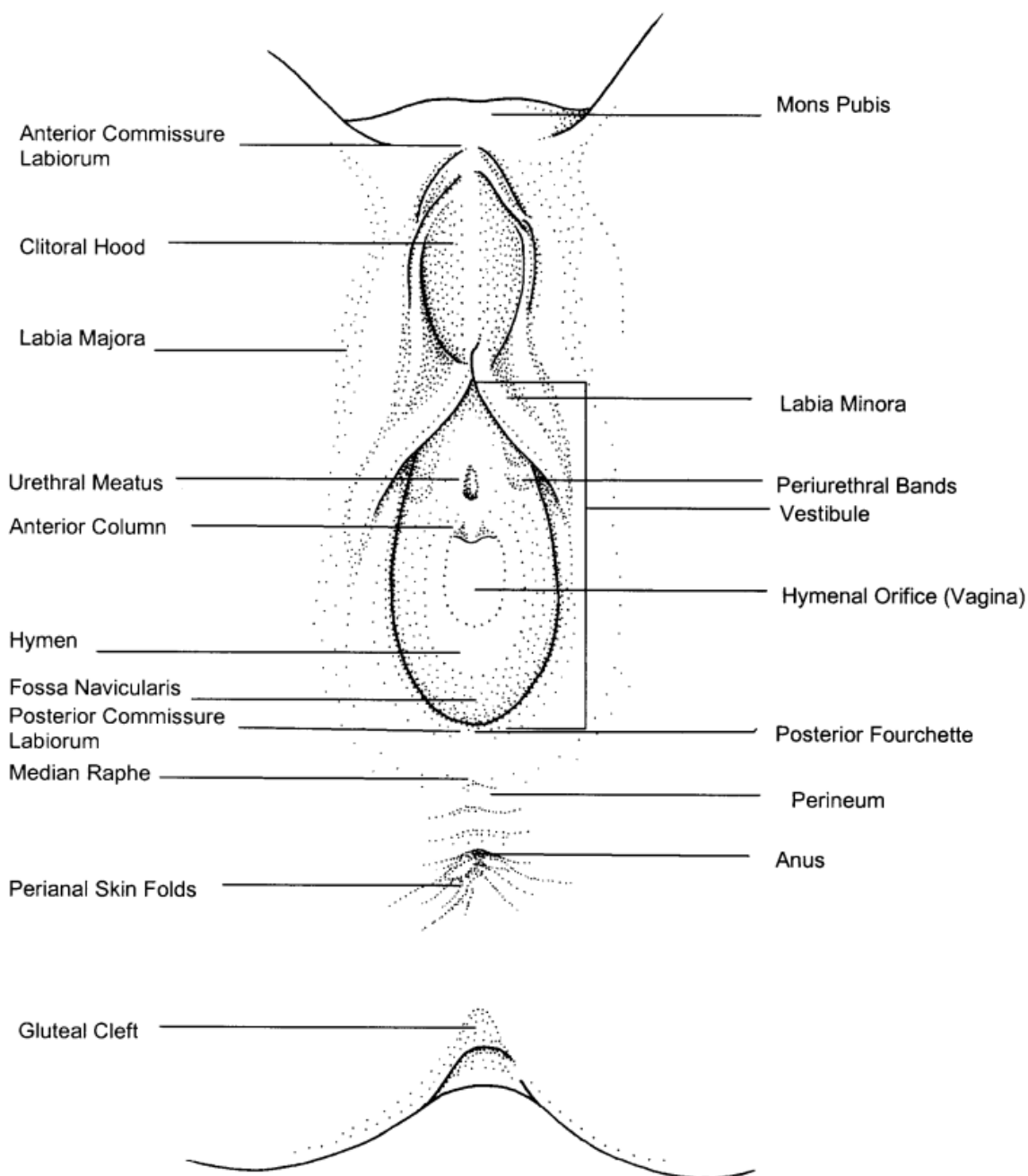
Supine Labial Traction

**Prone
Knee- Chest**



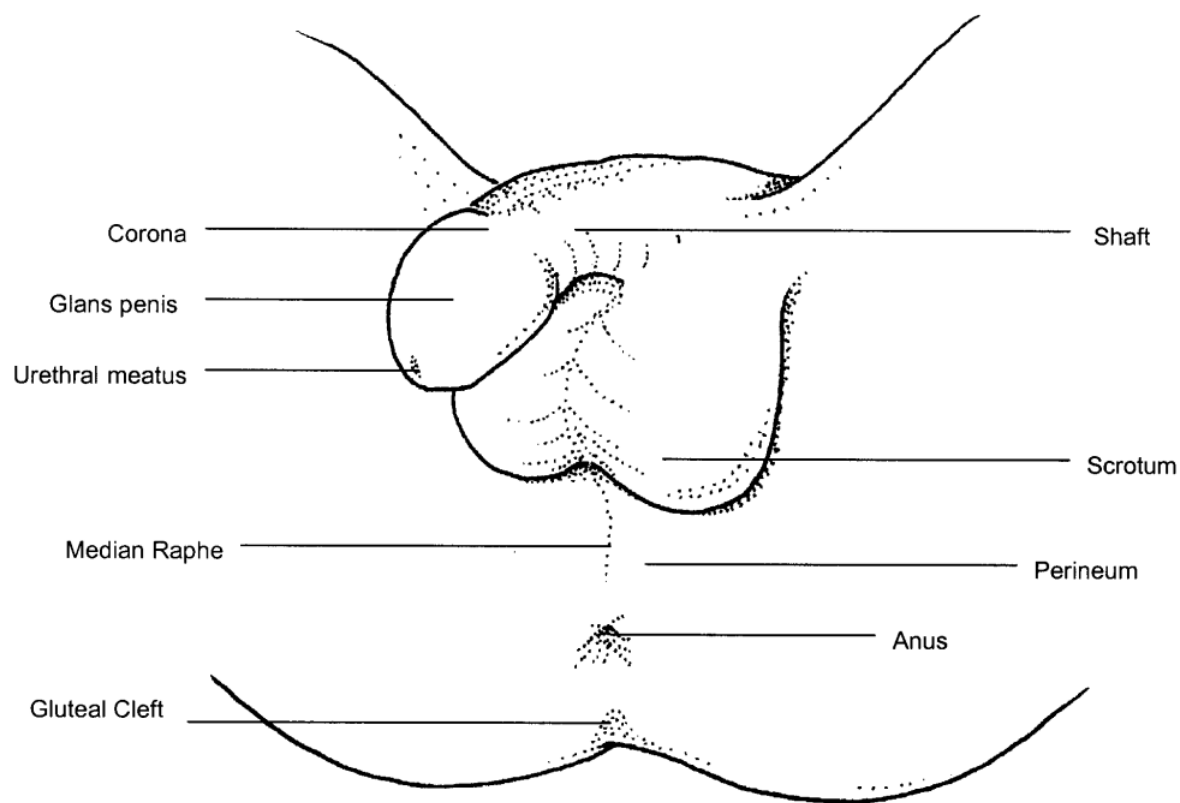
Labeled Diagrams of Genital Anatomy

*Female Genital Anatomy*²⁴⁹



249 The illustration is from the California Office of Emergency Services (2001), reprinted with permission.

Male Genital Anatomy



250 The illustration is from the California Office of Emergency Services (2001)), reprinted with permission.

Post-Assault Medications

*Typically not indicated in acute child exams. STI testing should occur first.

Emergency contraception	Levonorgestrel 1.5 mg po x 1	Take medicine as soon as possible within 5 days after unprotected intercourse May be taken even if patient is using reliable birth control or has had a tubal ligation Confirm negative pregnancy test prior to giving medication
STI prophylaxis	Ceftriaxone*	For gonorrhea prophylaxis
	<i>PLUS</i>	
	Azithromycin 1 gm po x 1	For Chlamydia prophylaxis Take with food to decrease GI side effects
	<i>PLUS</i>	
	Metronidazole*	For trichomonas prophylaxis
	2 gm po x1	
	Hep B vaccine	If patient not fully immunized Refer for completion of 3 dose series
	Tdap	If more than 5 years since last Td, and open wound

* Metronidazole should not be taken within 24 hours after OR 24 hours before alcohol ingestion. Advise patients of Antabuse-like reaction if combined with alcohol. Patient may choose to defer treatment

- For pregnant patients, consider providing no prophylactic antibiotics. In this case, gonorrhea and chlamydia tests should be obtained at follow-up visit in 2 weeks. If prophylaxis is strongly desired, azithromycin is a Class B drugs

For penicillin allergic patients

There is a 5-10% incidence of concurrent cephalosporin allergy.

If late onset, atypical, or undocumented allergy: use Azithromycin, as above

If history of anaphylaxis or immediate hives - consider either:

- Azithromycin 1 gm po (no cephalosporin) -This is appropriate in areas of low gonorrhea prevalence. Retest for GC in follow up 2 weeks after assault OR
- Azithromycin 2 gm po at once (this will treat GC and Chlamydia, but is not generally recommended due to concern emerging resistance), may cause nausea

For updates, see newest [CDC STI treatment guidelines](#)

Photography - Overview And Tips

One Memory Card Per Child



Photo #1 is Identification

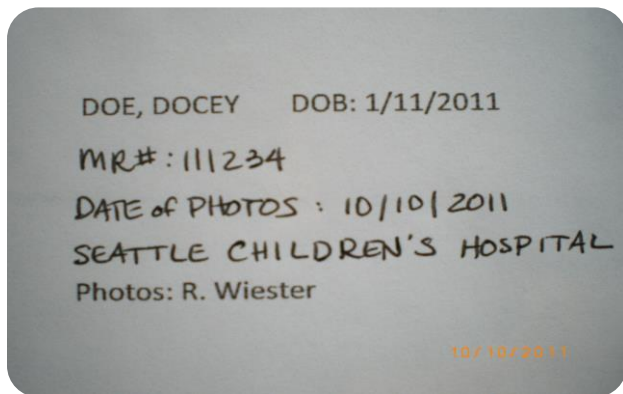


Photo #2 is Face / Body

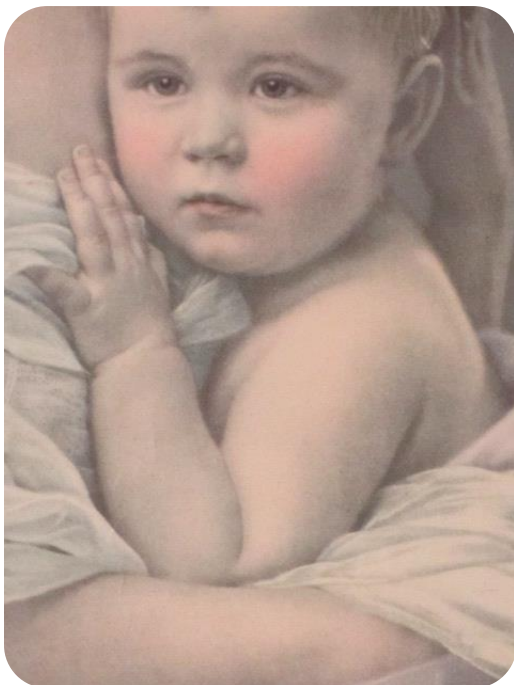


Photo #3 is Body Part with Injury About 3 Feet Away.



**Photo #4 is Close up of Injury, About 1 Foot
Away at 90 Degrees.**



Photo #5 is Injury with Measuring Device.



**** Repeat Process for Each Injury**

Sample Trafficked Victims Charting Aid

Gender of client: Female Male Other: _____

Age of client: _____ Date of birth: _____ Country of birth: _____

Number of years of schooling completed: _____

Client's preferred language: _____

Who all does client live with and relationship: _____

1. Has anyone ever (check all that apply)

- Withhold payment from you
- Give your payment to someone else
- Control the payment that you have been paid
- None of the above

2. Have you ever worked (or done other activities) that were different from what you promised or told?

No

Yes → What were you promised or told that you would do?

→What did you end up doing?

3. Did anyone where you lived or worked (or did other activities) ever make you feel scared or unsafe?

No

Yes → What made you feel scared or unsafe?

4. Did anyone where you lived or worked (or did other activities) ever hurt you or threatened to hurt you?

No

Yes → What did they do or say?

(pg. 1)

5. Were you ever injured or did you ever get sick in a place where you lived or worked (or did other activities)?

No

Yes →Were you ever stopped from getting medical care? Y N
→What happened?

6. Have you ever felt you could not leave the place where you lived or worked (or did other activities)?

No

Yes →Why couldn't you leave?

→What do you think would have happened if you did try to leave?

7. Did anyone where you lived or worked (or did other activities) tell you to lie about your age or what you did?

No

Yes →Why did they tell you to lie?

8. Did anyone where you lived or worked (or did other activities) ever trick or pressure you into doing anything you did not want to do?

No

Yes →Examples?

9. Did anyone ever pressure you to touch someone or have any unwanted physical or sexual contact?

No

Yes →What happened?

(pg. 2)

10. Did anyone ever take a photo of you that you were uncomfortable with?

No

Yes →Who took the photo?

→What did they want to do with the photo, if you know?

→Did you agree to this? Y N

11. Did you ever have sex for things of value (for example: money, housing, food, gifts, or favors)?

No

Yes →Were you pressured to do this? Y N

→Were you under the age of 18 when this occurred? Y N

12. Did anyone take and keep your identification (for example: your passport or driver's license)?

No

Yes →Could you get them back if you wanted, explain?

13. Did anyone where you worked (or did other activities) ever take your money for things (for example: for transportation, food, or rent)?

No

Yes →Did you agree to this person taking your money? Y N

→Describe:

(pg. 3)

	Partner 1	Partner 2	Partner 3
Male or Female			
Force			
Threat to harm			
Restrained			
Hit			
Kicked			
Choked/Strangled			
Pattern Injury			
Substance Use			
Voluntary (type/amount)			
Forced (type/amount)			
DFSA (Y/N)			
Type of Contact	Check all that apply		
Penis to: Vagina			
Anal			
Mouth			
Other			
Hand to: Vagina			
Anal			
Mouth			
Other			
Mouth to: Vagina			
Anal			
Mouth			
Other			
Condom Used (Y/N)			
Ejaculation and Location			

Sexual Identity Terms

These terms are to help you understand a little bit more about LGBTQ populations. They are not meant to be used in charting. They should be used with discretion considering potential bias.

Bisexual | A person emotionally, romantically or sexually attracted to more than one sex, gender or gender identity though not necessarily simultaneously, in the same way or to the same degree.

Cisgender | A term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth.

Gay | A person who is emotionally, romantically or sexually attracted to members of the same gender.

Gender dysphoria | Clinically significant distress caused when a person's assigned birth gender is not the same as the one with which they identify.

Gender expression | External appearance of one's gender identity, usually expressed through behavior, clothing, haircut or voice, and which may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine.

Gender-fluid | A person who does not identify with a single fixed gender.

Gender identity | One's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.

Genderqueer | Genderqueer people typically reject notions of static categories of gender and embrace a fluidity of gender identity and often, though not always, sexual orientation. They may see themselves as being both male and female, neither male nor female or as falling completely outside these categories.

Gender transition | The process by which some people strive to more closely align their internal knowledge of gender with its outward appearance. Some people socially transition, whereby they might begin dressing, using names and pronouns and/or be socially recognized as another gender. Others undergo physical transitions in which they modify their bodies through medical interventions.

Lesbian | A woman who is emotionally, romantically or sexually attracted to other women.

Pansexual | Describes people who are capable of being attracted to multiple sexes or gender identities.

Queer | A term people often use to express fluid identities and orientations. Often used interchangeably with "LGBTQ."

Sexual orientation | An inherent or immutable enduring emotional, romantic or sexual attraction to other people.

Transgender | An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.

Sexually Transmitted Infections in Children and Adolescents According to Syndrome - Guidelines for Treatment

Preferred regimens are listed. For revised recommendations on treatment of sexually transmitted infections have been issued by the Centers for Disease Control and Prevention in 2015^a; updates are posted at www.cdc.gov/std/treatment.

Syndrome	Organisms/Diagnoses	Treatment of Adolescent	Treatment of Infant/Child
Urethritis and cervicitis	<i>Neisseria gonorrhoeae</i> ,	Ceftriaxone, 250 mg, IM, in a single dose ^b	Children <45 kg and <8 y of age:
Urethritis:	<i>Chlamydia</i>	PLUS EITHER	Ceftriaxone, 125 mg, IM, in a single dose ^b
Inflammation of urethra with erythema and/or mucoid, mucopurulent, or purulent discharge	<i>trachomatis</i> Other causes of urethritis and cervicitis include <i>Mycoplasma genitalium</i> , possibly	Azithromycin, 1 g, orally, in a single dose OR Doxycycline, 100 mg, orally, twice a day for 7 days	PLUS Erythromycin base or ethylsuccinate, 50 mg/kg per day, orally, in 4 divided doses (maximum 2 g/day) for 14 days
Cervicitis: Inflammation of cervix with erythema, friability and/or mucopurulent or purulent cervical discharge. Cervicitis occurs rarely in prepubertal girls (see Prepubertal vaginitis, below)	<i>Ureaplasma urealyticum</i> , and sometimes <i>Trichomonas vaginalis</i> and herpes simplex virus (HSV)		Children ≥45 kg but <8 y of age: Ceftriaxone, 250 mg, IM, in a single dose ^b PLUS Azithromycin, 1 g, orally, in a single dose Children ≥45 kg and ≥8 y of age: Ceftriaxone, 250 mg, IM, in a single dose ^b PLUS EITHER Azithromycin, 1 g, orally, in a single dose OR Doxycycline, 100 mg, orally, twice a day for 7 days
Prepubertal vaginitis (STI related):	<i>N gonorrhoeae</i> ^a	...	Children <45 kg: Ceftriaxone, 125 mg, in a single dose Children ≥45 kg but <8 y of age: Ceftriaxone, 250 mg, IM, in a single dose ^b PLUS Azithromycin, 1 g, orally, in a single dose

Syndrome	Organisms/Diagnoses	Treatment of Adolescent	Treatment of Infant/Child
			<p>Children ≥ 45 kg and ≥ 8 y of age: Ceftriaxone, 250 mg, IM, in a single dose^b</p> <p>PLUS EITHER Azithromycin, 1 g, orally, in a single dose</p> <p>OR Doxycycline, 100 mg, orally, twice a day for 7 days</p>
	<i>C trachomatis</i> ^a	...	<p>Children < 45 kg: Erythromycin base or ethylsuccinate, 50 mg/kg per day, orally, in 4 divided doses (maximum 2 g/day) for 14 days</p> <p>Children ≥ 45 kg but < 8 y of age: Azithromycin, 1 g, orally, in a single dose</p> <p>Children ≥ 45 kg and ≥ 8 y of age: Azithromycin, 1 g, orally, in a single dose</p> <p>OR Doxycycline, 100 mg, orally, twice a day for 7 days</p>
	<i>T vaginalis</i>	...	<p>Children < 45 kg: Metronidazole, 45 mg/kg per day, orally, in 3 divided doses (maximum 2 g/day) for 7 days</p>
	Bacterial vaginosis	...	<p>Children < 45 kg: Metronidazole, 45 mg/kg per day, orally, in 3 divided doses (maximum 2 g/day) for 7 days</p>
	HSV—1 st clinical episode		<p>Children < 45 kg: Acyclovir, 80 mg/kg per day, orally, in 4 divided doses (maximum 3.2 g/day) for 7–10 days</p> <p>OR</p>

Syndrome	Organisms/Diagnoses	Treatment of Adolescent	Treatment of Infant/Child
Adolescent vulvovaginitis	<i>T vaginalis</i>	Metronidazole, 2 g, orally, in a single dose OR	Valacyclovir, 40 mg/kg per day, orally, in 2 divided doses for 7–10 days Children ≥45 kg: Acyclovir 400 mg, orally, 3 times/day for 7–10 days OR Acyclovir 200 mg, orally, 5 times/day for 7–10 days OR Famciclovir 250 mg, orally, 3 times/day for 7–10 days OR Valacyclovir 1 g, orally, twice daily for 7–10 days
	Bacterial vaginosis	Tinidazole, 2 g, orally, in a single dose Metronidazole, 500 mg, orally, twice daily for 7 days OR Metronidazole gel 0.75%, 1 full applicator (5 g), intravaginally, once a day for 5 days OR Clindamycin cream 2%, 1 full applicator (5 g), intravaginally at bedtime, for 7 days	...
	<i>Candida</i> species	See Table 4.5, Recommended Regimens for Vulvovaginal Candidiasis (p 904)	...
	HSV—1 st clinical episode	Acyclovir 400 mg, orally, 3 times/day for 7–10 days OR Acyclovir 200 mg, orally, 5 times/day for 7–10 days OR Famciclovir 250 mg, orally, 3 times/day for 7–	...

Syndrome	Organisms/Diagnoses	Treatment of Adolescent	Treatment of Infant/Child
Pelvic inflammatory disease (PID)	<i>N gonorrhoeae</i> , <i>C trachomatis</i> , anaerobes, coliform bacteria, and <i>Streptococcus</i> species	10 days	
		OR Valacyclovir 1 g, orally twice daily for 7–10 days See Pelvic Inflammatory Disease (Table 3.48, p 607)	PID occurs rarely, if at all, in prepubertal girls
Syphilis	<i>Treponema pallidum</i>	Penicillin G benzathine, 50 000 U/kg, IM up to the adult dose of 2.4 million U in a single dose. See Syphilis , p 755, for treatment of late latent syphilis, tertiary syphilis or neurosyphilis.	Aqueous crystalline penicillin G 200 000-300 000 U/kg/day IV, administered as 50 000 U/kg/dose, every 4–6 hours for 10 days.
Genital ulcer disease	<i>T pallidum</i>	Penicillin G benzathine, 50,000 U/kg, IM up to the adult dose of 2.4 million U in a single dose. See Syphilis , p 755, for treatment of late latent syphilis, tertiary syphilis or neurosyphilis.	Aqueous crystalline penicillin G 200 000-300 000 U/kg/day IV, administered as 50 000 U/kg/dose, every 4–6 hours for 10 days.
	HSV—1 st clinical episode	Acyclovir, 400 mg, orally, 3 times/day for 7–10 days OR Acyclovir, 200 mg, orally, 5 times/day for 7–10 days OR Famciclovir, 250 mg, orally, 3 times/day for 7–10 days OR Valacyclovir, 1 g, orally, twice daily for 7–10 days	Children <45 kg: See prepubertal vaginitis, above
	<i>Haemophilus ducreyi</i> (chancroid)	Azithromycin, 1 g, orally, in a single dose OR Ceftriaxone, 250 mg, IM, in a single dose OR Ciprofloxacin, 500 mg, orally, twice daily for 3	Children <45 kg: Ceftriaxone, 50 mg/kg, IM, in a single dose (maximum 250 mg) OR Children <45 kg: Azithromycin, 20 mg/kg, orally, in a single dose

Syndrome	Organisms/Diagnoses	Treatment of Adolescent	Treatment of Infant/Child
		days ^c	(maximum 1 g)
		OR	
		Erythromycin base, 500 mg, orally, 3 times/day for 7 days	
	<i>Klebsiella granulomatis</i> (granuloma inguinale [Donovanosis]) ^{a,d}	Doxycycline, 100 mg, orally, twice a day for at least 3 wk and until all lesions have healed completely (preferred)	
		OR	
		Azithromycin, 1 g, orally, once/wk for at least 3 wk and until all lesions have healed completely	
		OR	
		Ciprofloxacin, 750 mg, orally, twice a day for at least 3 wk and until all lesions have healed completely	
		OR	
		Erythromycin base, 500 mg, orally, 4 times/day for at least 3 wk and until all lesions have healed completely	
		OR	
		Trimethoprim-sulfamethoxazole, 1 double-strength (160 g/800 mg) tablet, orally, twice a day for at least 3 wk and until all lesions have healed completely	
Epididymitis	<i>C trachomatis</i> , <i>N gonorrhoeae</i>	Ceftriaxone, 250 mg, IM, in a single dose	
		PLUS EITHER	
		Doxycycline, 100 mg, orally, twice daily for 10 days	
		OR	
		Tetracycline, 500 mg, orally, 4 times/day for 10 days	

Syndrome	Organisms/Diagnoses	Treatment of Adolescent	Treatment of Infant/Child
		OR Azithromycin, 1 g, orally, each wk for 2 wk	
	Enteric organisms (for patients allergic to cephalosporins and/or tetracycline)	Levofloxacin, 500 mg, orally, once daily for 10 days	...
Gonococcal infections of the pharynx	<i>N gonorrhoeae</i>	OR Ofloxacin, 300 mg, orally, twice a day for 10 days Ceftriaxone, 250 mg, IM, in a single dose	PLUS Ceftriaxone, 125 mg, IM, in a single dose
Anogenital warts	Human papillomavirus	PLUS Azithromycin, 1 g, orally, in a single dose <i>Patient-applied:</i> Podofilox 0.5% solution or gel ^c OR Imiquimod 3.75% or 5% cream OR Sinecatechins 15% ointment <i>Provider-administered:</i> Cryotherapy OR Trichloroacetic acid or bichloroacetic acid 80%–90% OR Surgical removal	

Sexual Maturation Stages

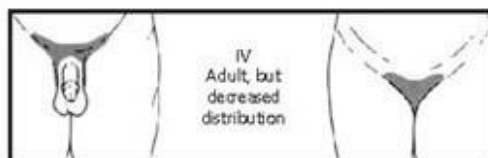
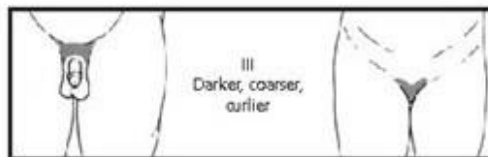
Stages Range from 1 (Prepubertal) to 5 (Adult Development)

Stages	Girls—Breast Development	Girls and Boys—Pubic hair	Boys—External Genitalia Development
<i>Tanner Stage 1</i>	<i>Prepubertal Only the papilla is elevated above the level of the chest wall</i>	<i>Prepubertal (velus hair similar to abdominal hair)</i>	<i>Prepubertal (velus hair similar to abdominal hair) Testes, scrotal sac, and penis have size similar to early childhood</i>
<i>Tanner Stage 2</i>	<i>Breast budding, elevation of breasts as small mounds, enlargement and widening of areolae. May be tender and not symmetrical bilaterally</i>	<i>Sparse growth of long, slightly pigmented, downy, straight or curled hair on labia majora or at the base of the penis</i>	<i>Enlargement of scrotum and testes; scrotum skin will thin and may be reddened</i>
<i>Tanner Stage 3</i>	<i>Breast enlarges, elevating beyond the areolae</i>	<i>Pubic hair becomes curly, coarser, extends outward over junction of pubes</i>	<i>Penis lengthening, testicles continue to grow</i>
<i>Tanner Stage 4</i>	<i>Breast enlarges and areolae and papilla form secondary mounds</i>	<i>Hair adult in type, but covers smaller area, no spread to the medial surface of thighs</i>	<i>Penis and testicles grow, scrotum darker in color</i>
<i>Tanner Stage 5</i>	<i>Breast achieves adult contour</i>	<i>Hair adult in type and quantity extends onto medial thigh</i>	<i>Adult genitalia</i>

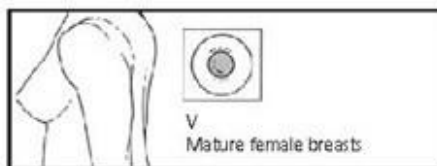
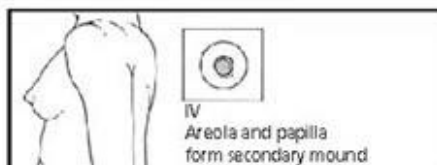
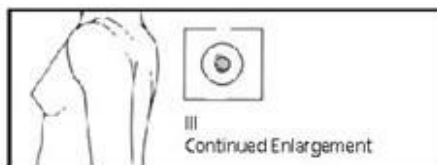
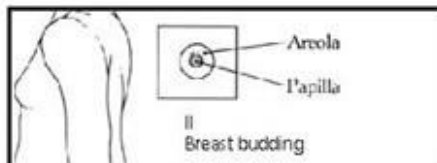
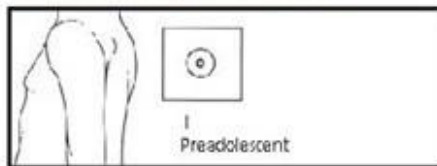
Changes in Girls and Boys at Various Stages of Sexual Maturation

(Original illustration from Johnson, Moore, & Jefferies. (1978). Permission to use obtained from Abbott Laboratories, Nutrition Research and Development.)

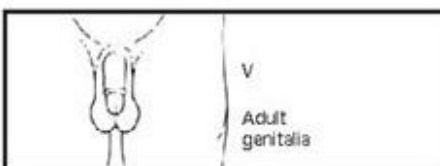
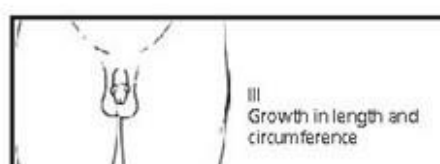
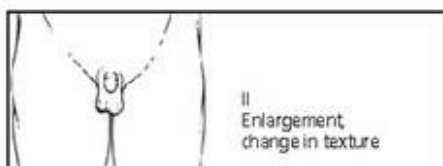
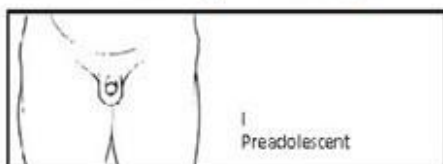
Pubic Hair Growth in Boys and Girls



Breast Development in Girls



Genitalia Development in Boys




Strangulation Addenda (Double-click images to open PDFs)

- *Assessment Card*

STRANGULATION ASSESSMENT CARD			
SIGNS	SYMPTOMS	CHECKLIST	TRANSPORT
<ul style="list-style-type: none"> Red eyes or spots (Petechiae) Neck swelling Nausea or vomiting Unsteady Loss or lapse of memory Unurinated Defecated Possible loss of consciousness Ptosis – droopy eyelid Droopy face Seizure Tongue injury Lip injury Mental status changes Voice changes 	<ul style="list-style-type: none"> Neck pain Jaw pain Scalp pain (from hair pulling) Sore throat Difficulty breathing Difficulty swallowing Vision changes (spots, tunnel vision, flashing lights) Hearing changes Light headedness Headache Weakness or numbness to arms or legs Voice changes 	<p>S Scene & Safety. Take in the scene. Make sure you and the victim are safe.</p> <p>T Trauma. The victim is traumatized. Be kind. Ask: what do you remember? See? Feel? Hear? Think?</p> <p>R Reassure & Resources. Reassure the victim that help is available and provide resources.</p> <p>A Assess. Assess the victim for signs and symptoms of strangulation and TBI.</p> <p>N Notes. Document your observations. Put victim statements in quotes.</p> <p>G Give. Give the victim an advisal about delayed consequences.</p> <p>L Loss of Consciousness. Victims may not remember. Lapse of memory? Change in location? Urination? Defecation?</p> <p>E Encourage. Encourage medical attention or transport if life-threatening injuries exist.</p>	<p>If the victim is Pregnant or has life-threatening injuries which include:</p> <ul style="list-style-type: none"> Difficulty breathing Difficulty swallowing Petechial hemorrhage Vision changes Loss of consciousness Unurinated Defecated <p>DELAYED CONSEQUENCES Victims may look fine and say they are fine, but just underneath the skin there would be internal injury and/or delayed complications. Internal injury may take a few hours to be appreciated. The victim may develop delayed swelling, hematomas, vocal cord immobility, displaced laryngeal fractures, fractured hyoid bone, airway obstruction, stroke or even delayed death from a carotid dissection, bloodclot, respiratory complications, or anoxic brain damage.</p> <p><small>Talafiero, E., Hawley, D., McClane, G.E. & Strack, G. (2008), Strangulation in Intimate Partner Violence. Intimate Partner Violence: A Health-Based Perspective. Oxford University Press, Inc.</small></p> <p><small>This project is supported all or in part by Grant No. 2014-TA-AI-K008 awarded by the Office on Violence Against Women, U.S. Dept. of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.</small></p>


- *Recommendations for Evaluation*



RECOMMENDATIONS for the MEDICAL/RADIOGRAPHIC EVALUATION of ACUTE ADULT, NON-FATAL STRANGULATION

Prepared by Bill Smock, MD and Sally Sturgeon, DNP, SANE-A
Office of the Police Surgeon, Louisville Metro Police Department

Endorsed by the National Medical Advisory Committee: Bill Smock, MD, Chair; Cathy Baldwin, MD; William Green, MD; Dean Hawley, MD; Ralph Rivello, MD; Heather Rizzo, MD; Steve Stopczynski, MD; Ellen Talafiero, MD; Michael Weaver, MD



GOALS:

1. Evaluate carotid and vertebral arteries for injuries
2. Evaluate bony/cartilaginous and soft tissue neck structures
3. Evaluate brain for anoxic injury

Strangulation patient presents to the Emergency Department

History of and/or physical exam with ANY of the following:

- Loss of Consciousness (anoxic brain injury)
- Visual changes: "spots", "flashing light", "tunnel vision"
- Facial, intraoral or conjunctival petechial hemorrhage
- Ligature mark or neck contusions
- Soft tissue neck injury/swelling of the

History of and/or physical exam with:

- No LOC (anoxic brain injury)
- No visual changes: "spots", "flashing light", "tunnel vision"
- No petechial hemorrhage
- No soft tissue trauma to the neck

Strangulation - Checklist

Stangulation Symptom Checklist:	Details of the Strangulation:	
<input type="checkbox"/> Breathing changes or difficulty <input type="checkbox"/> Raspy or hoarse voice <input type="checkbox"/> Cough <input type="checkbox"/> Difficulty/pain when swallowing <input type="checkbox"/> “Thick” feeling in throat <input type="checkbox"/> Cognitive changes (memory loss/confusion/agitation/difficulty with word finding/restlessness) <input type="checkbox"/> Reported LOC or near LOC <input type="checkbox"/> Loss of urine <input type="checkbox"/> Loss of bowels <input type="checkbox"/> Vision changes <input type="checkbox"/> Thought were going to die <input type="checkbox"/> Nausea and /or vomiting <input type="checkbox"/> Scratches/red marks(jaw line, clavicles/neck/behind ears) <input type="checkbox"/> Bruising(jaw line, clavicles/neck/behind ears) <input type="checkbox"/> Bruising and swelling (lips/oral mucosa)	<input type="checkbox"/> One hand <input type="checkbox"/> Two hands (Right or Left) <input type="checkbox"/> Forearm (Right or Left) <input type="checkbox"/> Ligature <input type="checkbox"/> Concurrent smothering/suffocation <input type="checkbox"/> Duration of strangulation <input type="checkbox"/> Was patient shaken by neck <input type="checkbox"/> Was patient suspended by neck (lifted off ground)	
Noted Injuries:		
<input type="checkbox"/> Pt evaluated for strangulation by ED MD prior to SANE arrival <input type="checkbox"/> Pt referred back to ED MD for strangulation evaluation		
<input type="checkbox"/> Strangulation discharge instructions reviewed with pt including: Stay with someone for 24 hours after strangulation event Return to ED for Difficulty breathing, increased trouble swallowing, swelling of neck or throat, increased hoarseness or voices changes, blurred vision, severe headaches, numbness of arms or legs.		
Examiner name (print)	Examiner signature	Date

Testing Template

Initial Testing				
	Vaginal	Rectal	Pharyngeal	Urethral
GC	Urine (NAAT)	Swab (Culture)	Swab (Culture)	Swab (Culture)
CT	Urine (NAAT)	Swab (Cx or NAAT)	-	Swab (Cx or NAAT)
Trichomonus	Swab (Wetmount)	-	-	-
Herpes/Ulcers	Swab (Viral Medium)	-	-	-
BV/Discharge	Swab (Culture)	-	-	-

	Female (♀)	Male (♂)
Dirty Urine	NAAT (vag. GC, CT)	Rectal Swab
Rectal Swab	Cx, NAAT (GC, CT)	Periurethral (discharge) Swab
Vulvar Swab	TV	Pharyngeal Swab
Pharyngeal Swab	Cx (GC)	Cx, NAAT, GC, CT

Follow-Up Testing (as indicated)	Other (as indicated)
<p>Upg</p> <p>Urine NAAT</p> <p>RPR (3m)</p> <p>HIV (1.3m)</p> <p>? Siblings</p>	<p>Urine:</p> <ul style="list-style-type: none"> • Pregnancy Test (≥9y) • Tox Screen (<120hrs) <p>Blood:</p> <ul style="list-style-type: none"> • HIV • RPR • Hepatitis B/C • Blood alcohol/tox (<24hrs)