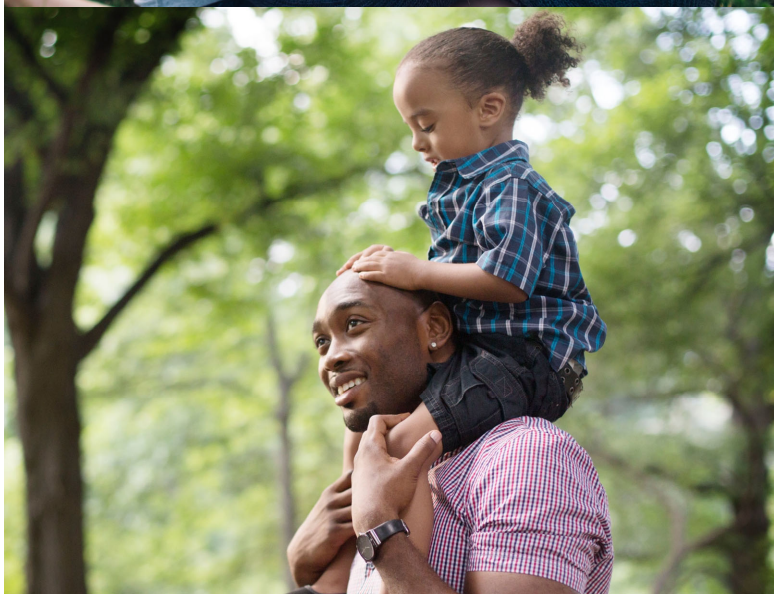
UK HealthCare
KENTUCKY CHILDREN'S HOSPITAL

BEST CHILDREN'S HOSPITALS U.S.News ORTHOPEDICS 2021-22

BEST CHILDREN'S HOSPITALS U.S.News CARDIOLOGY & HEART SURGERY 2021-22

Sexual Abuse and STI Update for 2021



The Joint Heart Program, a collaboration of Kentucky Children's Hospital and Cincinnati Children's, is jointly ranked by *U.S. News and World Report*.

Objectives

After this session participants will be able to:

- Review best practices for the evaluation of children who may have experienced sexual assault/abuse
- Describe resources available for aiding in the assessment of a child who may have experienced sexual assault/abuse
- Identify appropriate STI testing strategies for children who have experienced sexual abuse
- Know how to refer children who have experienced sexual assault/abuse for subsequent care

Financial Disclosure

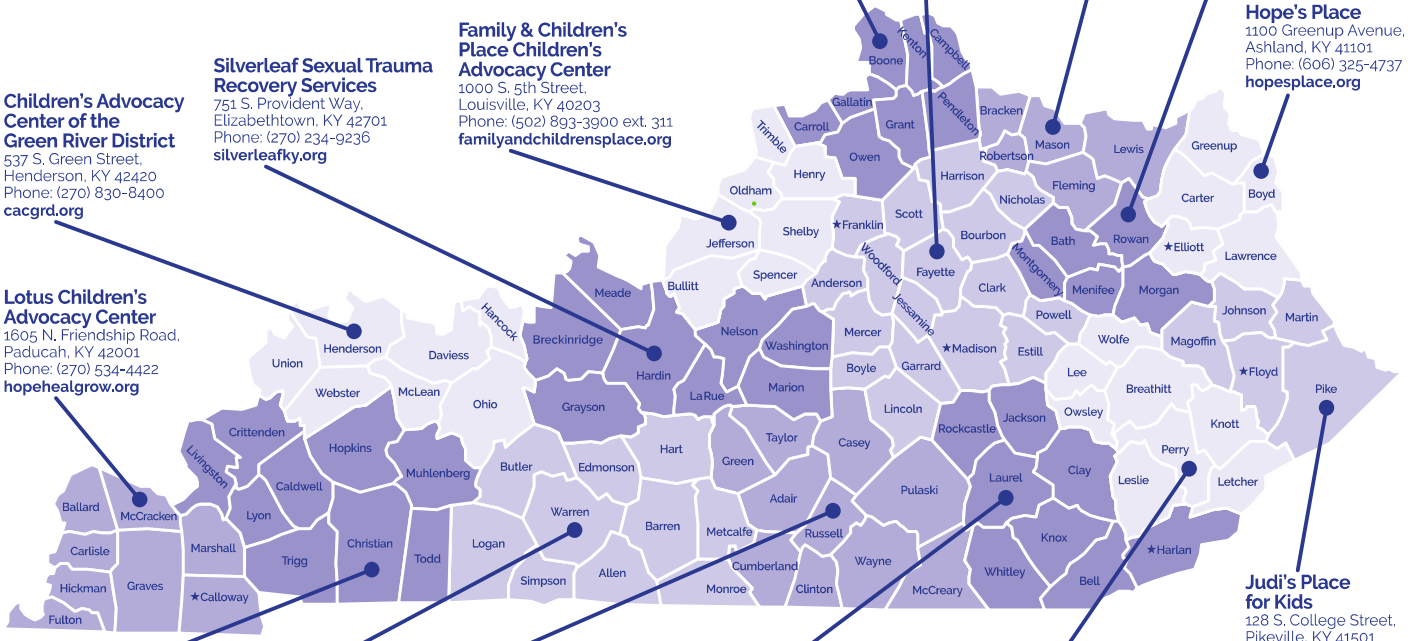
- I have nothing to disclose.


Children's Advocacy Center
A healing place for sexually abused children and their families.
Changing the Child Abuse System
WHAT HAPPENS TODAY WHEN KIDS NEED HELP FOR ABUSE
"This Place is Great"
Robin tells her story, while a detective, CPS worker, and State's Attorney listen as a team.
Robin can see a doctor.
Robin is referred to a counselor, who will help her heal.
Robin's mom talks to an advocate to help her understand the system.
Robin comes to the CAC with her mom.
Tells her teacher that she is being hurt by her mom's new boyfriend at home.
Start Here
. . . Robin talks to 3 people

Children's Advocacy Centers of Kentucky

For more information on each CAC, see www.cackentucky.org

- ● Main Office
- ★ Satellite Office
  Please contact main office for information about satellite office coverage in this service area.



Northern Kentucky Children's Advocacy Center
4890 Houston Road,
Florence, KY 41042
Phone: (859) 442-3200
nkycac.org

Buffalo Trace Children's Advocacy Center
224 Limestone Street,
Maysville, KY 41056
Phone: (606) 563-0572
btcac.org

Children's Advocacy Center of the Bluegrass
162 N. Ashland Avenue,
Lexington, KY 40502
Phone: (859) 225-5437
kykids.org

Gateway Children's Advocacy Center
310 E. Main Street,
Morehead, KY 40351
Phone: (606) 780-7848
gatewaycac.com

Hope's Place
1100 Greenup Avenue,
Ashland, KY 41101
Phone: (606) 325-4737
hopesplace.org

Family & Children's Place Children's Advocacy Center
1000 S. 5th Street,
Louisville, KY 40203
Phone: (502) 893-3900 ext. 311
familyandchildrensplace.org

Silverleaf Sexual Trauma Recovery Services
751 S. Provident Way,
Elizabethtown, KY 42701
Phone: (270) 234-9236
silverleafky.org

Children's Advocacy Center of the Green River District
537 S. Green Street,
Henderson, KY 42420
Phone: (270) 830-8400
cacgrd.org

Lotus Children's Advocacy Center
1605 N. Friendship Road,
Paducah, KY 42001
Phone: (270) 534-4422
hopehealgrow.org

Judi's Place for Kids
128 S. College Street,
Pikeville, KY 41501
Phone: (606) 437-7447
judisplace.org
Floyd Co. Satellite Office Phone:
(606) 886-8520

Kentucky River Children's Advocacy Center
465 Cedar Street,
Hazard, KY 41701
Phone: (606) 487-9173
carecottage.org

Cumberland Valley Children's Advocacy Center
1130 E. 4th Street,
London, KY 40741
Phone: (606) 878-9116
cv-cac.org
Harlan Co. Satellite Office Phone:
(606) 621-5228

Lake Cumberland Children's Advocacy Center
427 S. Main Street,
Jamestown, KY 42629
Phone: (270) 343-6922

Pennyrile Children's Advocacy Center
1102 E. 21st Street,
Hopkinsville, KY 42240
Phone: (270) 881-1111
pennyrilecac.org

Barren River Area Child Advocacy Center
103 E. 12th Street,
Bowling Green, KY 42101
Phone: (270) 783-4357
bracac.org

What's New

- A model medical protocol was created to guide the evaluation of pediatric patients who report sexual assault/abuse.
- A website was created for medical providers seeking information related to the care of children who experience sexual assault/abuse.
- Kentucky Board of Nursing recognized the SANE-P designation. Sexual Assault Nurse Examiners can evaluate and collect evidence when children present for care after having experienced recent sexual assault/abuse.
- A course is in the final stages of development to train nurses who want to obtain the SANE-P credential.

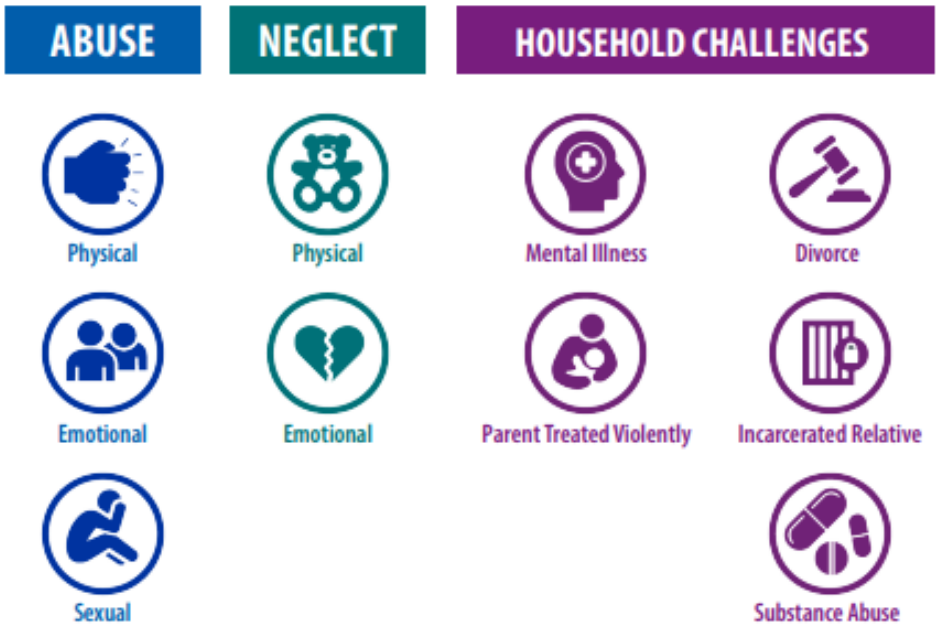
What's New

- The KY State Crime Lab has revised the Sexual Assault Forensic Evidence (SAFE) kit.
- CDC MMWR Sexually Transmitted Infection Treatment Guidelines, 2021 edition have been released.
- The AAP RED BOOK 2021 has also been updated to reflect the CDC MMWR STI guideline changes.
- The Children's Advocacy Centers in Kentucky have increased involvement in evaluating many children who experience abuse in the Commonwealth.

What's Not New:
Child Sexual Assault/Abuse Is Not

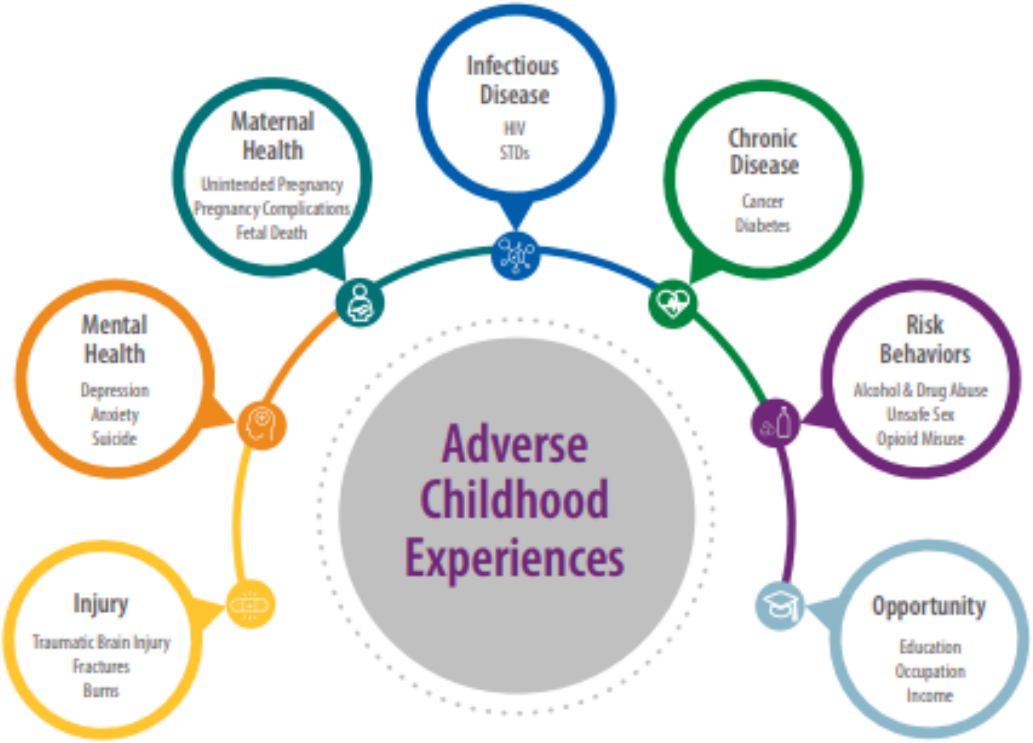
- Uncommon
- Limited to only one segment, race, gender, socioeconomic strata of the population
- A social problem alone but also a public health problem

Adverse Childhood Experiences (ACEs)



CDC

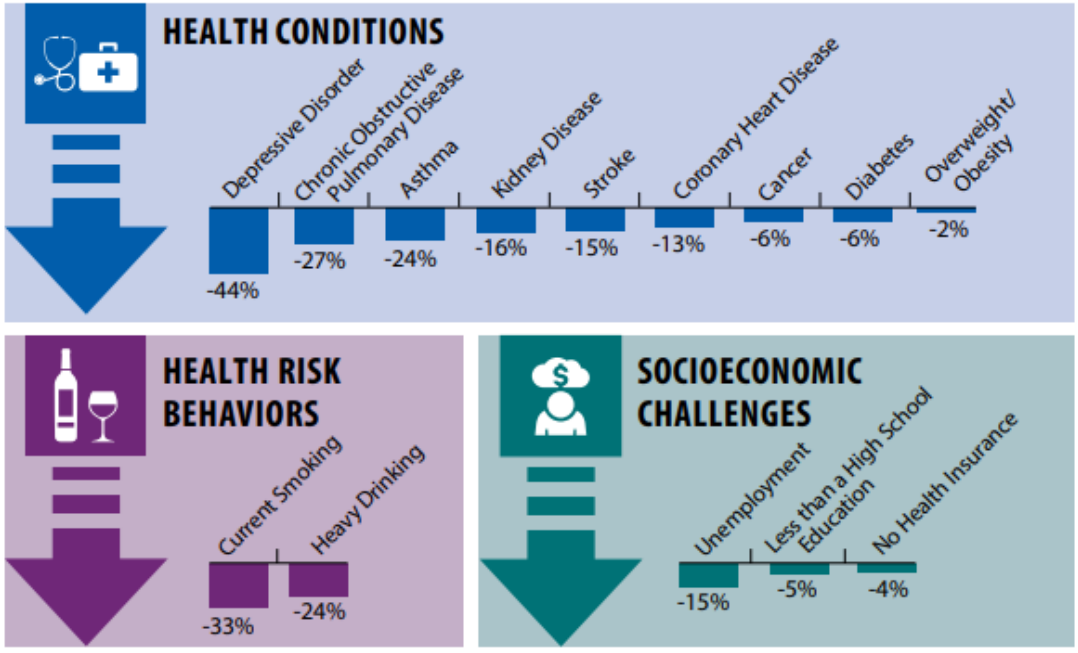
Negative Health Outcomes Associated with ACEs (CDC)



Long Term Effects of Sexual Abuse

- Chronic health problems (heart diseases, cancer, obesity)
- Low self-esteem
- Suicide attempts
- School academic difficulties/ school failure
- Regressive behavior
- Sexual behavior problems
- PTSD
- Substance abuse
- Sexual promiscuity
- Prostitution
- Delinquent behavior

Potential Reduction in Negative Outcomes in Adulthood (CDC) : Preventing ACEs Could Lead to a Reduction in a Large Number of Health Conditions, Health Risk Behaviors and Socioeconomic Challenges



Source: Merrick et al, 2019 (ACEs Vital Signs)

Sexual Abuse -- There are Many Definitions

- Involvement of a children in sexual activities that they cannot understand and provide consent due to their age and development.
- A betrayal of trust by the perpetrator: The perpetrator has authority and power over the child due to his or her age or position.
- A type of maltreatment that refers to the involvement of the child in sexual activity to provide sexual gratification or financial benefit to the perpetrator, including contacts for sexual purposes, molestation, statutory rape, prostitution, pornography, exposure, incest, or other sexually exploitative activities. (Child Maltreatment 2016).
- Intrafamilial sexual abuse violates family taboos.

Types of Sexual Abuse Are Numerous

- Exposing perpetrator genitalia to the victim
- Masturbation and other sexual acts in front of the victim
- Voyeurism
- Using a victim for production of pornography
- Rape, sodomy, engaging a child in sexual activity
- Fondling or touching of the child's private parts
- Touching designed for the sexual gratification of the perpetrator
- Penetration of the vagina, anus or mouth
- Human Trafficking
- Genital Mutilation

Human Trafficking Can Involve Sexual Abuse/Violence

- Child sex trafficking refers to the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a minor for the purpose of a commercial sex act.
- Offenders target vulnerable children who are lured by offers of food, clothes, attention, friendship, love, and a seemingly safe place to sleep.
- Trafficker engages the child in prostitution and uses physical, emotional, and psychological abuse to keep the child trapped in a life of prostitution.
- Traffickers commonly isolate victims by moving them far away from friends and family, altering their physical appearances, or continuously moving them to new locations.
- Victims are heavily conditioned to remain loyal to the trafficker and to distrust law enforcement.

Female Genital Mutilation

- Involves the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons.
- Has no health benefits for girls and women.
- Can cause severe bleeding and problems urinating, and later cysts, infections, as well as complications in childbirth and increased risk of newborn deaths.
- More than 200 million girls and women alive today have been cut in 30 countries in Africa, the Middle East and Asia.
- FGM is mostly carried out on young girls between infancy and age 15.
- FGM is a violation of the human rights of girls and women.
- Treatment of health complications of FGM in 27 high prevalence countries costs 1.4 billion USD per year.
- Class B Felony in Kentucky
- Is included in the definition of “abused or neglected child” in Kentucky

Child Sexual Abuse Statistics

- The true scope of the problem may better be reflected in retrospective surveys of adults. (Finkelhor)
- Research conducted by the Centers for Disease Control (CDC) estimates that approximately 1 in 13 boys and 1 in 4 girls experience some form of sexual abuse in childhood.

Adolescent Sexual Abuse

- Teens 16 to 19 years of age were 3 ½ times more likely than the general population to be victims of rape, attempted rape, or sexual assault.
- Surveys of high school students indicate that 10% of females and 3 to 7 % of males report forced sex.
- Teens may be victims of intrafamilial abuse by parents, caregivers, siblings and other relatives.
- Teens may also experience interpersonal violence by a current or ex-partner.
- Approximately 1 in 5 female high school students report being physically and/or sexually abused by a dating partner.
- Approximately 1 in 7 (13%) youth Internet users received unwanted sexual solicitations and 4% of youth Internet users received aggressive solicitations, in which solicitors made or attempted to make offline contact with youth.
- Teens who identify as LGBTQ may have an equal or greater chance of experiencing sexual violence compared with self-identified heterosexuals.

Clinical Decision Tool for Evaluating Pediatric/Adolescent Sexual Assault/Abuse

- Contact local advocacy agency to request victim advocate
- Consult Hospital SW per hospital protocol
- Contact SANE-A/A or SANE-P/A for case consultation, per facility protocol and as appropriate for patient's sexual development. If SANE unavailable, proceed according to your facility protocol.
- Per KRS 216.400, each victim shall have the right to determine whether a report shall be made to law enforcement. **It is required to report to Child Protective Services or law enforcement where there is suspected abuse of a child, in all cases of suspected sex trafficking of a minor, and in all cases of female genital mutilation.** (KRS 216B.400, KRS 620.030, and KRS 600.020)
  - Kentucky Department for Community Based Services Hotline 1-877-597-2331

- Immediate medical or mental health needs always take priority over evidence collection
- Physician, NP or PA should provide medical clearance

Patient reports **sexual abuse/assault** within the last **96 hours** and/or there is **potential to recover biologic or trace evidence**

Yes

- **Maintain ongoing consent and/or assent**
- **Obtain information from investigators first, if available**
- **Obtain non leading medical history from caregiver without child present, and from child without caregiver present (See medical protocol)**
- **Perform mental health assessment (screen for substance use, self-harm)**
- **Assess for signs of strangulation**
- **Complete head to toe assessment including anogenital exam**
- **Collect Sexual Assault Forensic Evidence (SAFE) Kit (as indicated in the medical protocol)**
- **Record all injuries and/or points of tenderness with written and photographic documentation**
- **Assess and/or perform as appropriate:**
  - **Urine drug screen**
  - **Drug Facilitated Sexual Assault Urine/Blood Collection Kit**
  - **STI testing**
  - **HIV Risk Assessment**
  - **Pregnancy Testing**
  - **STI Prophylaxis**
  - **Emergency Contraception (Up to 120 hours)**
  - **HIV Prophylaxis (up to 72 hours)**
- **Consider additional testing and treatment based on symptoms**
- **Assess for safe discharge plan**

No

- **Maintain ongoing consent and/or assent**
- **Obtain information from investigators first, if available**
- **Obtain non leading medical history from caregiver without child present, and from child without caregiver present (See medical protocol)**
- **Perform mental health assessment (screen for substance use, self-harm)**
- **Complete head to toe assessment**
- **Complete anogenital exam, unless timely follow-up can be assured, and patient is asymptomatic**
- **Assess and/or perform as appropriate:**
  - **STI testing**
  - **HIV Risk Assessment**
  - **Pregnancy Testing**
  - **STI Prophylaxis**
  - **Emergency Contraception (Up to 120 hours)**
- **Consider additional testing and treatment based on symptoms**
- **Assess for safe discharge plan**

Clinical Decision Tool for Evaluating Pediatric/Adolescent Sexual Assault/Abuse

- Contact local advocacy agency to request victim advocate
- Consult Hospital SW per hospital protocol
- Contact SANE-A/A or SANE-P/A for case consultation, per facility protocol and as appropriate for patient's sexual development. If SANE unavailable, proceed according to your facility protocol.
- Per KRS 216.400, each victim shall have the right to determine whether a report shall be made to law enforcement. It is required to report to Child Protective Services or law enforcement where there is suspected abuse of a child, in all cases of suspected sex trafficking of a minor, and in all cases of female genital mutilation. (KRS 216B.400, KRS 620.030, and KRS 600.020)
  - Kentucky Department for Community Based Services Hotline 1-877-597-2331

Kentucky Medical Protocol for Child Sexual Assault/Abuse Evaluations

- This protocol is designed to be a guide for health care providers who conduct child sexual assault and abuse medical forensic evaluations of prepubertal and adolescent children and should be used in conjunction with patient history, clinical assessment and judgement, patient consent, and in compliance with state and federal laws.
- Immediate medical or mental health needs take priority over evidence collection.
- If a child is prepubertal, then a SANE-P/A can evaluate the child for sexual assault/abuse **in collaboration with a physician, nurse practitioner or physician's assistant.**

Purpose of the Medical Evaluation are Myriad

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

Do No Harm: Provide Trauma Informed Care

- Incorporate an understanding of traumatic stress and related responses into routine encounters with children and families.
- Provide basic interventions to children and families that will minimize the potential for ongoing trauma and maximize continuity of care.

Healthcare Providers should identify, prevent, and treat traumatic stress responses at the time of need and within scope of practice

Reduce Distress

- **Actively assess and treat pain, using your hospital's protocol.**
- **Provide child with information about what is happening and choices regarding treatment decisions when possible.**
- **Listen carefully for child's understanding and clarify any misconceptions.**
- **Ask about fears and worries.**
- **Provide reassurance and realistic hope.**

Promote Emotional Support

- **Empower parents to comfort and help their child.**
- **Encourage child's involvement in age-appropriate activities when possible.**

Remember the Family

- **Gauge family distress and other life stressors; identify family strengths and coping resources.**
- **Encourage parents to use own coping resources or support available at the hospital or in the community.**

Taking A History From A Child Who Has Experienced Sexual Assault/Abuse

- Obtain as much history as possible from collateral sources without the child present (investigators, caregiver).
- Obtain a trauma informed, developmentally appropriate, medical history from the child that will help with clinical decision making and guide medical decision making.
- Establish rapport; ask non-leading questions.
  - Why did you have to come to see the doctor today?
  - Sometimes kids come to see me if something happened to their bodies that they didn't like/made them not feel safe/that they didn't understand. Has anything like that ever happened to you?

Before the Exam

- Caregiver Considerations
  - Discuss exam
  - Discuss concerns
  - Obtain consent when applicable
  - In general, sedation for the sole purpose of forensic evidence collection is not recommended (if there is concern for acute injury that needs immediate identification and management, then sedation may be necessary)

Before the Exam

- Patient Considerations
  - Discuss exam that will be age, gender identity, developmentally and culturally appropriate
  - Discuss concerns
  - Obtain consent/assent
  - Discuss with patient what you will tell caregiver if you are speaking to the caregiver separate from the patient
  - Discuss how the exam can be paused or stopped if the patient changes her mind
  - Show the swab you may use to touch the genitalia

Before the Exam

- Prepare the room
  - ?Door secure ?Windows with drapes/blinds
  - Sheet, drapes, replacement underwear/clothes
  - Supplies
    - Camera
    - SAFE Kit
    - STI swabs
    - Phlebotomy supplies
  - Demonstrate/show the child the equipment and swabs
  - Help
    - Child Life
    - Victim Advocate
    - Healthcare provider assistant

Provide Patient with Opportunity to Make Choices and Feel in Control

- Choice of support person
- Choice of blanket
- Choice of something to distract (music, iPad, book, drawing pad)
- Would they like to help with the exam? Watch the exam?
- What to check first/where to start
- Frog or butterfly legs or stirrups
- Exam does not have to be “all or nothing”
- Explain to the patient that if they are scared or in pain, then the exam can be paused/stopped if they say “stop”/tell you

Conduct a Comprehensive Physical Exam that is age, gender identity, developmentally and culturally appropriate

- If translator is needed for caregiver or patient, have translator turn their back to exam and respect patient's privacy.
- Keep parts of the body not being examined covered and uncover body parts as exam progresses.

Physical Examination

- The exam can be performed with a caretaker or support person present if the patient desires one. Examiner **must have** a nurse or tech present to both assist and chaperone.
- Complete a head to toe exam.
- Examine for and document any areas of tenderness.
- Examine and document any abnormal findings including bruising, bite marks, abrasions, petechiae, etc.
- Assess the oropharynx to check for injuries to frenula, palatal petechiae, or abrasions to the buccal mucosa.
- Assess the neck and breast (these are high yield areas for contusions and saliva).
- Assess areas that might be hidden by hair but are injured such as ears and behind the ears.
- Assess for signs of strangulation (neck injuries, subconjunctival hemorrhage, facial petechiae, and hoarseness, difficulty or pain with swallowing).
- Examine the abdomen for tenderness or masses.
- Assess for other signs of nonaccidental trauma (pattern injuries, injuries to locations not commonly injured accidentally like the ears, neck, cheek, torso, genitalia, hands and feet).

Head to Toe Assessment

- Assess for medical conditions
- Assess for injury
  - Accidental
  - Inflicted
  - Self inflicted

Bruise and Injury Descriptors

- Location
- Size
- Color
- Shape
- Pattern
- Tenderness

Bruises and Their Ages

- **Dating of bruises is imprecise**. The appearance of a bruise can vary depending on the depth, evaluator's perception of color, the ambient lighting, the victim's skin color. **It is advisable to describe the bruise rather than postulate how old it is.**

Self Harm

Head to toe exam

TEN-4-FACES-p

- TORSO
- EARS
- NECK
- Less than 4 years old or any bruise in an infant less than 4 months
- FRENULUM
- ANGLE OF THE JAW
- CHEEKS (fleshy)
- Eyelids
- SUBCONJUNCTIVAL HEMORRHAGE
- Patterned bruising

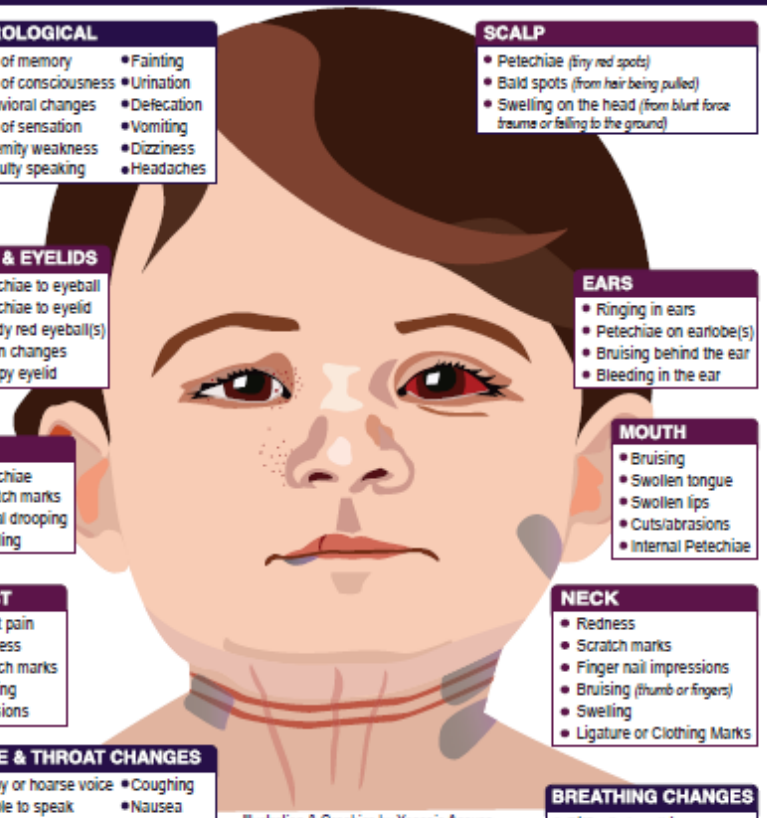
TEN-4-FACES-p

Pierce, M. C., Kaczor, K., Lorenz, D. J., Bertocci, G., Fingarson, A. K., Makoroff, K., Berger, R. P., Bennett, B., Magana, J., Staley, S., Ramaiah, V., Fortin, K., Currie, M., Herman, B. E., Herr, S., Hymel, K. P., Jenny, C., Sheehan, K., Zuckerbraun, N., Hickey, S., … Leventhal, J. M. (2021). Validation of a Clinical Decision Rule to Predict Abuse in Young Children Based on Bruising Characteristics. *JAMA network open*, *4*(4), e215832. https://doi.org/10.1001/jamanetworkopen.2021.5832

- A multicenter cross-sectional study of 2161 children younger than 4.0 years found the TEN-4-FACESp Bruising Clinical Decision Rule (BCDR) to be 95.6% sensitive and 87.1% specific for distinguishing abuse from nonabusive trauma. The BCDR was comprised of 3 components: (1) **body region bruised** (torso, ear, neck, frenulum, angle of jaw, cheeks [fleshy], eyelids, and subconjunctivae), (2) **bruising anywhere on an infant 4.99 months and younger**, or (3) **patterned bruising.** In this study, an affirmative finding for any of the 3 BCDR TEN-4-FACESp components **in children younger than 4 years** indicated a potential risk for abuse warranting further evaluation.

Signs and Symptoms of STRANGULATION

(visible signs may not be present)



NEUROLOGICAL

- Loss of memory
- Loss of consciousness
- Behavioral changes
- Loss of sensation
- Extremity weakness
- Difficulty speaking
- Fainting
- Urination
- Defecation
- Vomiting
- Dizziness
- Headaches

SCALP

- Petechiae *(tiny red spots)*
- Bald spots *(from hair being pulled)*
- Swelling on the head *(from blunt force trauma or falling to the ground)*

EYES & EYELIDS

- Petechiae to eyeball
- Petechiae to eyelid
- Bloody red eyeball(s)
- Vision changes
- Droopy eyelid

EARS

- Ringing in ears
- Petechiae on earlobe(s)
- Bruising behind the ear
- Bleeding in the ear

FACE

- Petechiae
- Scratch marks
- Facial drooping
- Swelling

MOUTH

- Bruising
- Swollen tongue
- Swollen lips
- Cuts/abrasions
- Internal Petechiae

CHEST

- Chest pain
- Redness
- Scratch marks
- Bruising
- Abrasions

NECK

- Redness
- Scratch marks
- Finger nail impressions
- Bruising *(thumb or fingers)*
- Swelling
- Ligature or Clothing Marks

VOICE & THROAT CHANGES

- Raspy or hoarse voice
- Unable to speak
- Trouble swallowing
- Painful to swallow
- Clearing the throat
- Coughing
- Nausea
- Drooling
- Sore throat
- Stridor

BREATHING CHANGES

- Difficulty breathing
- Respiratory distress
- Unable to breathe

Illustration & Graphics by Yesenia Aceves

Source: *Strangulation in Intimate Partner Violence, Chapter 15, Intimate Partner Violence. Oxford University Press, Inc. 2009.*

TRAINING INSTITUTE on STRANGULATION PREVENTION

strangulationtraininginstitute.com

v 10.5.2017

Assess for Signs of Strangulation

- Subconjunctival hemorrhage
- Neck bruising
- Scratch marks to neck
- Ligature marks on neck
- Facial or periorbital or eyelid petechiae

Assess for Symptoms of Strangulation

- Sore throat, difficulty swallowing
- Hoarse voice
- Sore neck
- Loss of memory, loss of consciousness
- Loss of bowel or bladder function

Assess Sexual Maturation

National Protocol for Sexual Assault Pediatric

Tanner Staging Ranges from 1 (Prepubertal) to 5 (Adult Development)[1]

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

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.)

Medical Examination of the Prepubertal Child

- Speculum exam is not routinely indicated during the evaluation of the prepubertal child
- The vaginal walls and cervix do not need to be inspected unless there is a concern for a tear or laceration of these structures, the source of vaginal bleeding is unknown, or presence of a foreign body is suspected
- A speculum exam should only be performed with sedation

The majority of children and adolescents who report sexual abuse and rape have normal examinations.

- **The nature of the abuse may not leave injury.**
- **Injuries heal rapidly.**
- **Disclosures of sexual abuse are often delayed.**
- **There may be discordance between what a child perceives has happened and the actual event (remember that the law defines rape as penetration no matter how *slight*, of the vagina or anus with any body part or object, or oral *penetration* by a sex organ of another person, without the consent of the victim).**
- **Peer reviewed medical literature supports that healing is rapid, and that exams are normal even in cases where perpetrators have confessed to sexual abuse, sexual abuse of a child was identified in pornographic videos, and in pregnant teenagers.**
- **Many children and adolescents who have a STI have normal anogenital exams.**

Child Sexual Abuse *Reality*

- The majority of sexually abused children will have a normal examination.
- McCann J, Miyamoto S, Boyle C, Rogers K. Healing of hymenal injuries in prepubertal and adolescent girls: a descriptive study. Pediatrics 2007; 119:e1094-e1106.
- McCann J, Miyamoto S, Boyle C, Rogers K. Healing of nonhymenal injuries in prepubertal and adolescent girls: a descriptive study. Pediatrics 2007; 120:1000-1011.

Evidence Collection When A Prepubertal Child Reports Sexual Abuse/Assault

- According to “502 KAR 12-010”: “If the sexual assault occurred within ninety-six (96) hours prior to the forensic-medical examination, a Kentucky State Police Sexual Assault Evidence Collection Kit shall be used.”
- At a minimum, forms contained in the kit and reference standards (buccal, blood, and when indicated the hair standards [Most current kit instructions available on http://cackentucky.org/medical-resources] should be completed, since other evidence (outside of the kit) could be collected by investigators. Other components of the kit can be completed on a case-by-case basis.
- Physical assessment for injury and documentation may still be indicated beyond 96 hours.
- Discuss with investigators that items such as clothing, bedding, and/or objects (condoms, sex toys, etc.) used during or after the assault may provide biologic forensic evidence that can be recovered and should be considered for collection.

Evidence Collection Guidelines

Prepubertal patient

- Discuss the exam and evidence collection process with the caregiver and patient. Proceed with caregiver's consent and patient's assent.
- Speculum exam should NOT be performed unless there is concern for intravaginal injury or foreign body. (In this situation, an exam should be performed with sedation/anesthesia).
- The current timeframes recommended for evidence collection in this document may be altered by advances in DNA methodology in the future.

Patient reports	**Time since assault**	**Recommended action regarding collection in addition to the standards (as discussed above). Additional collection may be considered as clinically indicated.**
Vaginal or anal penetration with penis or object	Less than or equal to 72 hours	Collection should include swabs of the external labia, the vaginal vestibule (area between the labia in front of the hymen), the perianal area and the anus. If hymenal injury, collection of intravaginal swabs for the kit would be indicated and can be considered up to 96 hours. This collection should occur with sedation or anesthesia.

Patient reports	**Time since assault**	**Recommended action regarding collection in addition to the standards (as discussed above). Additional collection may be considered as clinically indicated.**
Vaginal or anal penetration with penis or object	72-96 hours	Consider selected evidence collection including: Undergarments worn at the time of or immediately after the assault. Patient genital swabs can also be considered, especially if patient has not bathed. If hymenal injury, collection of intravaginal swabs for the kit would be indicated and can be considered up to 96 hours. This collection should occur with sedation or anesthesia.
Oral penetration with penis	Less than or equal to 24 hours	Collect evidence within the oral cavity. Consider additional evidence collection if there are concerns that the disclosure of assault/abuse is incomplete.
Oral penetration with penis	24-96 hours	Assess oral cavity for mucosal injury, petechiae, injury to frenula. Consider additional evidence collection if there are concerns that the disclosure of assault/abuse is incomplete.
Digital penetration of vagina or anus or hand to genital contact	Less than or equal to 24 hours	Collection should include swabs of the external labia, the vaginal vestibule (area between the labia in front of the hymen), the perianal area and the anus.
Digital penetration of vagina or anus or hand to genital contact	24-96 hours	Swabs in addition to the standards are not generally recommended unless patient has **not** bathed or urinated or defecated and there is a potential of bodily fluid transfer. Consider additional evidence collection if there are concerns that the disclosure of assault/abuse is incomplete.
Transfer of bodily fluids to extragenital body areas such as breast, neck, abdomen, thighs, etc.	Less than or equal to 96 hours	Recovery may be diminished with bathing, but additional evidence collection (by swabbing the identified areas) should still be strongly considered.

Patient reports	Time since assault	Recommended action regarding collection in addition to the standards (as discussed above). Additional collection may be considered as clinically indicated.
No history of sexual contact but acute unexplained anogenital injury that is not consistent with accidental trauma and/or raises concern for sexual abuse or inflicted injury	Timeframe unclear but likely less than or equal to 96 hours	Collection should include swabs of the external labia, the vaginal vestibule (area between the labia in front of the hymen), the perianal area and the anus. If hymenal injury, collection of intravaginal swabs for the kit would be indicated and can be considered up to 96 hours. This collection should occur with sedation or anesthesia.
No known sexual contact but suspicious circumstances (abduction, concern for trafficking, etc.)	Timeframe unclear but likely less than or equal to 96 hours	Collection should include swabs of the external labia, the vaginal vestibule (area between the labia in front of the hymen), the perianal area and the anus.
No clear history of sexual contact but child presents with symptoms (vaginal discharge, dysuria) and there is a nonspecific concern for sexual abuse based on history.	Timeframe is unclear	Evidence collection including standards is not typically indicated in this circumstance. Consider expert consultation.
No history of sexual contact, no concern for abuse by caretaker and child presents with anogenital complaints/symptoms or concerning or sexualized behaviors that could have another etiology.	Timeframe is unclear or unknown	Evidence collection including standards is not typically indicated. Recommend CAC referral/consultation for services.
No history of sexual contact, no symptoms, but caretaker is concerned about sexual abuse.	Timeframe is unclear or unknown	Evidence collection including standards not typically indicated. Recommend CAC referral/consultation for services.
Patient reports sexual contact.	Timeframe greater than 96 hours.	Evidence collection including standards not typically indicated acutely. Recommend CAC referral/consultation for services.

Pubertal Child (see "Definitions" section)
According to "502 KAR 12-010": "If the sexual assault occurred within ninety-six (96) hours prior to the forensic-medical examination, a Kentucky State Police Sexual Assault Evidence Collection Kit shall be used." See chart below.

- At a minimum, forms contained in the kit and reference standards (buccal, blood, and hair) should be completed, since other evidence (outside of the kit) could be collected by investigators.
- Evidence collection is indicated up to 96 hours. However, physical assessment, documentation of injury, STI prophylaxis and emergency contraception could still be indicated beyond this time frame. It is still prudent to discuss with investigators that items such as clothing, bedding, and/or objects (condoms, tampons, sex toys, etc.) used during or after the assault may still provide biologic forensic evidence that can be recovered and should be considered for collection.

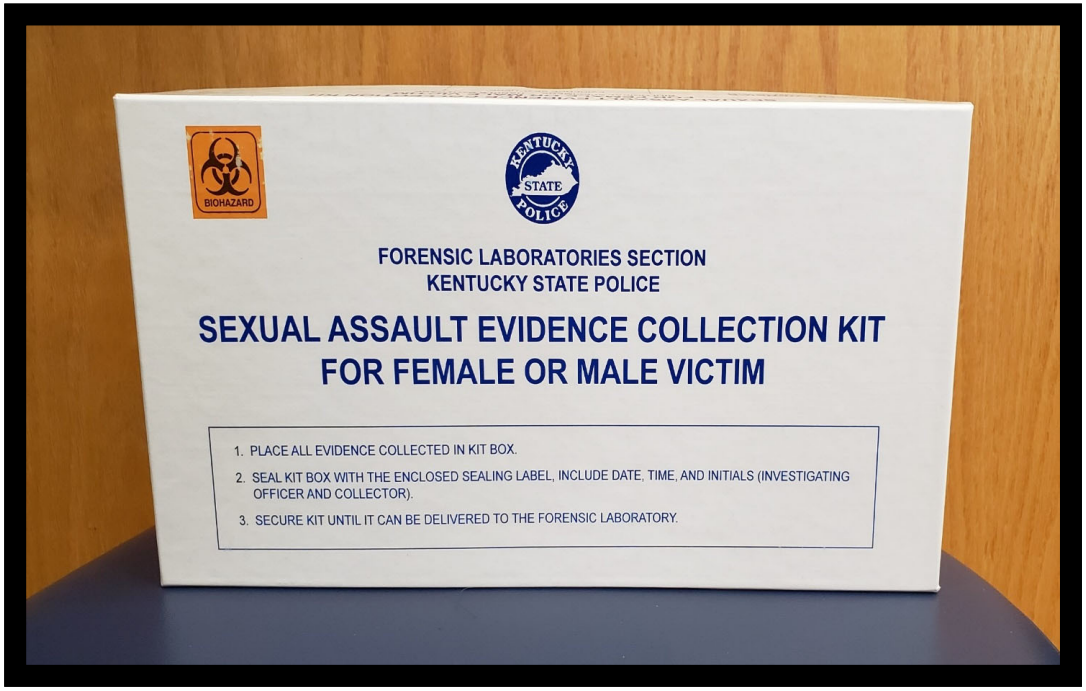
Pubertal Child

- Discuss the exam and evidence collection process with the patient. Proceed with patient consent.
- Decision to perform speculum exam should be made on a case-by-case basis, taking child's age, sexual history, and informed consent for this exam component into consideration. Extreme care should be taken when deciding whether a speculum exam will be performed for a young postmenarchal adolescent, to prevent further injury, pain, or trauma. Speculum exam is indicated if there is concern for intravaginal injury or foreign body. It should be noted that injury and/or foreign body, as well as trace evidence may be identified on exam of the vagina and cervix even in the absence of a patient history that raises concerns.
- The current timeframes recommended for evidence collection in this document may be altered by advances in DNA methodology in the future.

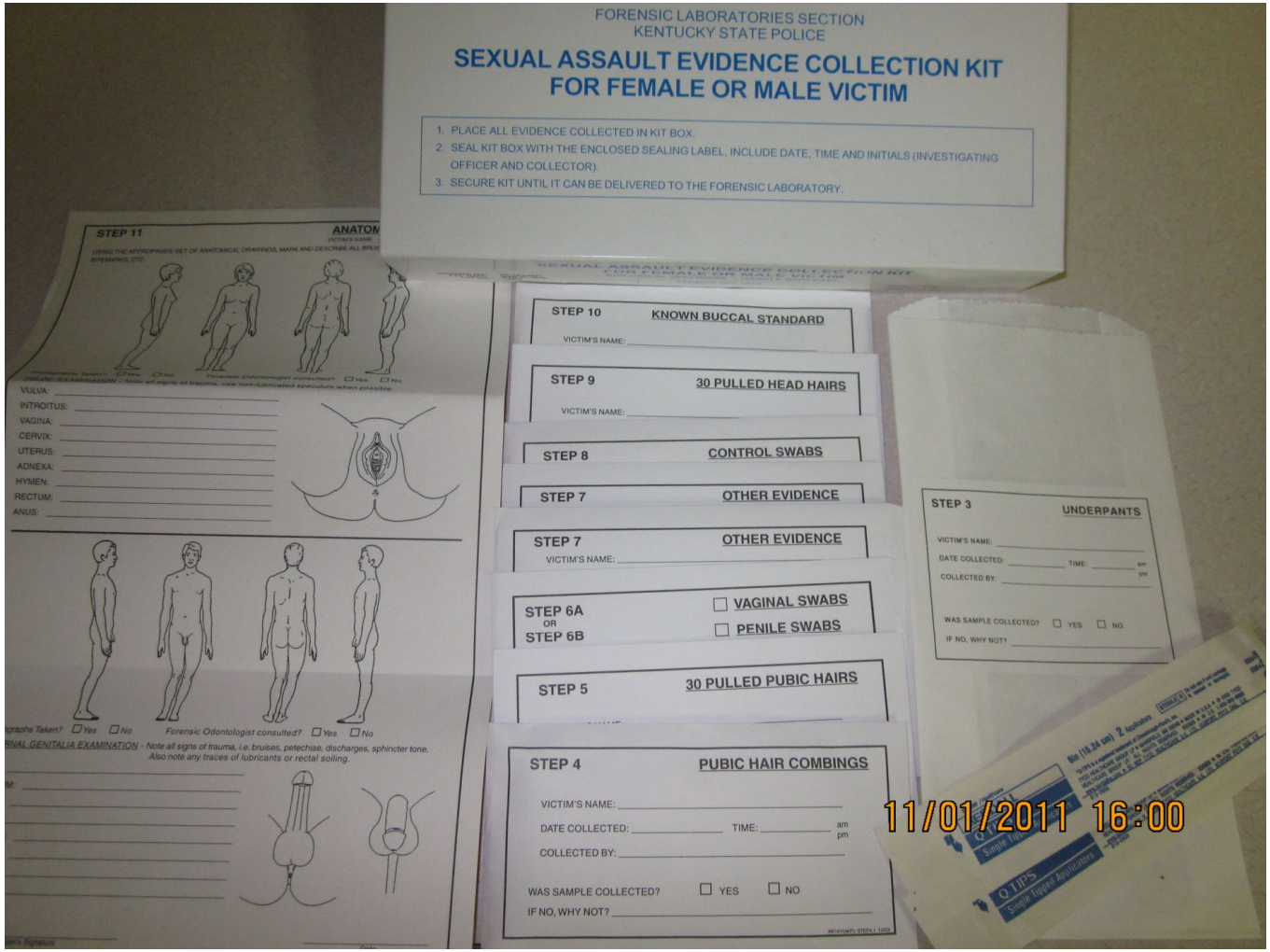
Patient reports	**Time since assault**	**Recommended action regarding evidence collection in addition to the standards (as discussed above). Additional collection may be considered as clinically indicated.**
Vaginal or anal penetration with penis or object	Less than or equal to 96 hours	Collection should include swabs of the external labia, the vaginal vestibule (area between the labia in front of the hymen), intravaginal swabs, and swabs of the perianal area and the anus.
Oral penetration with penis	Less than or equal to 24 hours	Collect evidence within oral cavity. Consider additional evidence collection if there are concerns that the disclosure of assault/abuse is incomplete.

Patient reports	**Time since assault**	**Recommended action regarding evidence collection in addition to the standards (as discussed above). Additional collection may be considered as clinically indicated.**
Oral penetration with penis	24-96 hours	Assess oral cavity for mucosal injury, petechiae, injury to frenula. Consider additional evidence collection if there are concerns that the disclosure of assault/abuse is incomplete.
Digital penetration of vagina or anus or hand to genital contact	Less than or equal to 24 hours	Collection should include swabs of the external labia, the vaginal vestibule (area between the labia in front of the hymen), intravaginal swabs, and swabs of the perianal area and the anus.
Digital penetration of vagina or anus or hand to genital contact.	24-96 hours	Swabs in addition to the standards are not generally recommended unless patient has **not** bathed or urinated or defecated and there is a potential of bodily fluid transfer. Consider additional evidence collection if there are concerns that the disclosure of assault/abuse is incomplete.
Transfer of bodily fluids to extragenital body areas such as breast, neck, abdomen, thighs, etc.	Less than or equal to 96 hours	Recovery may be diminished with bathing, but additional evidence collection (by swabbing the identified areas) should still be considered.
No history of contact but acute unexplained anogenital injury that is not consistent with accidental trauma and/or raises concern for sexual abuse or inflicted injury	Timeframe unclear but likely less than or equal to 96 hours.	Collection should include swabs of the external labia, the vaginal vestibule (area between the labia in front of the hymen), intravaginal swabs, and swabs of the perianal area and the anus.
No history of contact but patient presents with history of impairment AND there are concerns that a sexual assault occurred (patient was found in a state of undress, patient perceives possible unwanted sexual contact, or has anogenital symptoms related to possible sexual assault or abuse)	Less than or equal to 96 hours	Patient must be conscious and provide consent. Collection should include swabs of the external labia, the vaginal vestibule (area between the labia in front of the hymen), intravaginal swabs, and swabs of the perianal area and the anus.

Patient reports	**Time since assault**	**Recommended action regarding evidence collection in addition to the standards (as discussed above). Additional collection may be considered as clinically indicated.**
No history of sexual contact, no symptoms, but caretaker is concerned about sexual assault/abuse.	Timeframe unknown or unclear.	Any exam should be performed with patient consent. Evidence collection including standards not typically indicated. Consider CAC referral/consultation for services.
Patient reports sexual contact.	Greater than 96 hours.	Evidence collection including standards not typically indicated. Recommend CAC referral/consultation for services.



https://www.youtube.com/watch?v=UJBgdVmdBT0


FORENSIC LABORATORIES SECTION
KENTUCKY STATE POLICE
SEXUAL ASSAULT EVIDENCE COLLECTION KIT
FOR FEMALE OR MALE VICTIM
1. PLACE ALL EVIDENCE COLLECTED IN KIT BOX.
2. SEAL KIT BOX WITH THE ENCLOSED SEALING LABEL, INCLUDE DATE, TIME AND INITIALS (INVESTIGATING OFFICER AND COLLECTOR).
3. SECURE KIT UNTIL IT CAN BE DELIVERED TO THE FORENSIC LABORATORY.
STEP 11
VULVA:
INTROITUS:
VAGINA:
CERVIX:
UTERUS:
ADNEXA:
HYMEN:
RECTUM:
ANUS:
Forensic Odontologist consulted? Yes No
Also note any traces of lubricants or rectal soiling.
STEP 10 KNOWN BUCCAL STANDARD
VICTIM'S NAME:
STEP 9 30 PULLED HEAD HAIRS
VICTIM'S NAME:
STEP 8 CONTROL SWABS
STEP 7 OTHER EVIDENCE
STEP 7 OTHER EVIDENCE
VICTIM'S NAME:
STEP 6A OR STEP 6B
VAGINAL SWABS
PENILE SWABS
STEP 5 30 PULLED PUBIC HAIRS
STEP 4 PUBIC HAIR COMBINGS
VICTIM'S NAME:
DATE COLLECTED: TIME: am pm
COLLECTED BY:
WAS SAMPLE COLLECTED? YES NO
IF NO, WHY NOT?
STEP 3 UNDERPANTS
VICTIM'S NAME:
DATE COLLECTED: TIME: am pm
COLLECTED BY:
WAS SAMPLE COLLECTED? YES NO
IF NO, WHY NOT?
Q-TIPS
Single Tipped Applicators
11/01/2011 16:00

Forensic Evidence Collection

- Each state has specific time frames recommended for when evidence is collected.
- Evidence is collected if the possibility for recovery of biologic or trace evidence exists. In general this possibility is most likely if the most recent abuse occurred within the last 72-96 hours.
- **Indications for an acute exam include assessment for injury, etiology of any pain or bleeding, assessment for STI, or concern for suicidal ideation, pregnancy or transmission of HIV.**

Forensic Evidence Collection
Reality for Prepubertal Children

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

Speculum Exams in Pubertal Females

- Care should be taken when deciding to do a speculum exam in order to prevent further injury, pain or trauma.
- Indications for a speculum exam include:
  - Concern for a laceration.
  - The source of vaginal bleeding or pain is unknown.
  - The presence of a foreign body is suspected.

CDC MMWR STI Treatment Guidelines 2021

- Workowski KA, Bachmann LH, Chan PA, et al. Sexually Transmitted Infections Treatment Guidelines, 2021. MMWR Recomm Rep 2021;70(No. RR-4):1–187. DOI: http://dx.doi.org/10.15585/mmwr.rr7004a1external icon.

LABORATORY TESTING PREPUBERTAL CHILD
Perform STI testing in prepubertal children

- The child has experienced penetration or has evidence of recent or healed penetrative injury to the genitals, anus, or oropharynx.
- The child has been abused by a stranger.
- The child has been abused by an assailant known to be infected with an STI or at high risk for STIs (e.g., injecting drug user, MSM, person with multiple sex partners, or person with a history of STIs).
- The child has a sibling, other relative, or another person in the household with an STI.
- The child lives in an area with a high rate of STIs in the community.
- The child has signs or symptoms of STIs (e.g., vaginal discharge or pain, genital itching or odor, urinary symptoms, or genital lesions or ulcers).
- The child or parent requests STI testing.
- The child is unable to verbalize details of the assault.

STI testing for prepubertal children after sexual assault/abuse

- Culture or NAAT from the pharynx, rectum and vagina (or urine NAAT) in girls
- Culture or NAAT from the pharynx, rectum and urine (boys). For boys with a urethral discharge, a meatal swab specimen is adequate.
- Serum testing for syphilis, HIV, Hepatitis B
- For girls, trichomonas testing is recommended if other indications for vaginal testing exist. Urine or vaginal NAAT or culture.
- **When testing prepubertal children for gonorrhea and chlamydia with NAAT, only CLIA-validated, FDA-cleared NAAT assays should be used. <u>All positive results should be confirmed</u>.**

Organism/Syndrome	Specimens
Neisseria gonorrhoeae and *Chlamydia trachomatis*	Prepubertal: Culture or NAAT from pharynx, anus, vagina (in girls), and urine (in boys). For boys with a urethral discharge, a meatus swab specimen is adequate substitute for intraurethral swab specimen. Postpubertal: NAAT from sites of penetration or attempted penetration. May include rectum, throat, vagina or cervix (female), urethra (male).
Syphilis	Darkfield examination (if available) of chancre fluid; blood for serologic tests at time of abuse and 4–6 weeks and 3 months later.
Human immunodeficiency virus	Serologic testing of abuser (if possible); serologic testing of child at time of abuse and 6 weeks and 3 months later.
Hepatitis B virus	Serum hepatitis B surface antigen testing of abuser or hepatitis B surface antibody testing of child, unless the child has received 3 doses of hepatitis B vaccine. See Table 3.22 (p 398) for management.
Herpes simplex virus (HSV)	Culture or NAAT of lesion specimen; all virologic specimens should be typed (HSV-1 vs HSV-2).
Bacterial vaginosis (females only)	Prepubertal: Wet mount of a vaginal swab specimen for BV, if discharge is present. Postpubertal: Point-of-care testing and/or wet mount with measurement of vaginal pH and KOH application for the whiff test from vaginal secretions should be done for evidence of BV, especially if vaginal discharge, malodor, or itching is present.
Human papillomavirus	Clinical examination, with biopsy of lesion specimen, if diagnosis unclear.
Trichomonas vaginalis	Prepubertal: NAAT and/or culture and wet mount. Testing for *T vaginalis* should not be limited to girls with vaginal discharge if other indications for vaginal testing exist. Postpubertal: NAAT from vagina or urine.

American Academy of Pediatrics. *Red Book: 2021–2024 Report of the Committee on Infectious Diseases.* 32nd ed. American Academy of Pediatrics; 2021

Presumptive treatment/prophylaxis for children who have been sexually assaulted or abused is not routinely recommended
except when HIV nPEP or Hep B immunization/HBIG administration is indicated

- Do not delay initiation of HIV post-exposure prophylaxis (nPEP) or Hep B immunization/HBIG administration when it is indicated.
- The incidence of most STIs among children is low after abuse or assault.
- Prepubertal girls appear to be at lower risk for ascending infection than adolescent or adult women.
- Regular follow-up of children usually can be ensured.

HIV Nonoccupational Postexposure Prophylaxis (HIV nPEP) Considerations		
Type of Exposure within 72 Hours	**Assailant HIV status**	**Recommendation**
Assailant's: • Blood, • Semen, • Vaginal secretions, • Rectal secretions, • Breast milk, • Body fluid that is visibly contaminated with blood (for example saliva with blood)	**Known positive**	**Initiate nPEP**
Assailant's: • Blood, • Semen, • Vaginal secretions, • Rectal secretions, • Breast milk, • Body fluid that is visibly contaminated with blood (for example saliva with blood)	**Unknown**	**Consider on case by case basis** Consideration includes: • Type of assault/abuse described • Age of the assailant (juvenile assailant may decrease risk) • Presence of anogenital injury or genital ulcer or STI (may serve as a portal for infection) • Whether assault/abuse was ongoing by the SAME individual • Other high-risk factors for assailant and patient (drugs involvement, trafficking history, STIs, incarceration history) • Multiple assailants may increase risk
Assailant's secretions not visibly contaminated with blood: • Urine • Nasal secretions • Saliva • Sweat • Tears	**Regardless of assailant's HIV status**	**nPEP NOT recommended**

When determining if HIV nPEP is indicated, do not await assailant testing results.

- HIV prophylaxis should be started within 72 hours and as close to the time of sexual contact as possible.
- Consider possible adverse effects and likelihood of medication adherence prior to prescribing nPEP.
- CDC's data regarding the likelihood of HIV acquisition from **an infected source based on a single exposure may be helpful in decision making:**
  - The highest risk of acquisition is associated with receptive anal penetration.
  - The lowest risk of acquisition is associated with receptive oral and insertive oral intercourse.
  - The risk of HIV acquisition as a result of a **single** act of biting, spitting, sex toy sharing or having body fluids thrown at a person is negligible.
- **Resources for Providers**
  - HIV nPEP Consultation Services for Clinicians (1-888-448-4911)
  - For additional resources, visit Children's Advocacy Centers of Kentucky: https://www.cackentucky.org/medical

Hepatitis B

- Provide vaccination for Hepatitis B if child is unimmunized.
- If assailant is known Hepatitis B surface antigen positive and the survivor has not been previously vaccinated, administer Hep B vaccine and HBIG.
- If assailant is known Hepatitis B surface antigen positive and the survivor has been previously vaccinated, administer Hep B vaccine (booster dose).

Pubertal STI testing

- Patient has experienced penetration, however slight, or there is evidence of acute or healed penetrative injury to the genitals, anus, or oropharynx.
- Patient exhibits signs and/or symptoms of an STI (e.g., vaginal discharge or pain, genital itching or odor, urinary symptoms, abdominal pain, and genital lesions or ulcers).
- A sibling or relative or adult in the patient's environment has an STI.
- The assailant has a known STI or is at high risk for STIs (e.g., IV drug use, multiple sex partners, men who have sex with men, history of incarceration, or history of STIs).
- The assailant is a stranger.
- Patient lives in an area with a high rate of STIs in the community.
- The patient is requesting testing.
- Patient has already been diagnosed with one STI.
- Unclear history and there are reasons to believe patient is at risk for acquiring an STI.
- Follow up is difficult or unlikely.
- Patient is sexually active.

STI testing for pubertal children after sexual assault/abuse

- Culture or NAAT from the pharynx, rectum and vagina (or urine NAAT) in girls
- Culture or NAAT from the pharynx, rectum and urine (boys). For boys with a urethral discharge, a meatal swab specimen is adequate.
- Serum testing for syphilis, HIV, Hepatitis B
- For girls, trichomonas testing is recommended if other indications for vaginal testing exist. Urine or vaginal NAAT
- POC or wet mount with measurement of vaginal pH and KOH application for the whiff test from vaginal secretions should be performed for evidence of BV and candidiasis, especially if vaginal discharge, malodor, or itching is present.
- MSM should be offered screening for *C. trachomatis* and *N. gonorrhoeae* if they report receptive oral or anal sex during the preceding year, regardless of whether sexual contact occurred at these anatomic sites during the assault. Anoscopy should be considered in instances of reported anal penetration.

Prophylaxis of Adolescents for STIs After a Sexual Assault
CDC MMWR 2021

- Provide an empiric antimicrobial regimen for chlamydia, gonorrhea, and trichomonas for females and chlamydia and gonorrhea for males .
- Emergency contraception should be considered when the assault could result in pregnancy.
- Assess the need for Hepatitis B vaccination or HBIG.
- HPV vaccination children/adolescents aged 9–26 years who have not been vaccinated or are incompletely vaccinated. The vaccine should be administered at the time of the initial examination, and follow-up doses should be administered at 1–2 months and 6 months after the first dose. A 2-dose schedule (0 and 6–12 months) is recommended for persons initiating vaccination before age 15 years.
- Recommendations for HIV nPEP are made on a case-by-case basis according to risk and timeframe after the sexual assault.

STI Prophylaxis for Adolescents After a Sexual Assault
CDC MMWR 2021

Recommended Regimen for Adolescent and Adult Female Sexual Assault Survivors
Ceftriaxone 500 mg* IM in a single dose
plus
Doxycycline 100 mg 2 times/day orally for 7 days
plus
Metronidazole 500 mg 2 times/day orally for 7 days
* For persons weighing ≥150 kg, 1 g of ceftriaxone should be administered.

Pregnancy Assessment, Testing, and Emergency Contraception

- Inquire about patient's age of menarche, last menstrual cycle, and last consensual sexual contact (when developmentally appropriate to ask about consensual sexual contact).
- If within 120 hours (5 days) of sexual assault with known or possible exchange of penile secretions to the vagina of a menstruating female patient:
- Test for pregnancy with Urine Qualitative hCG and/or Serum Quantitative hCG
- Educate the patient/caregiver that the medication can help prevent pregnancy by delaying ovulation. Emergency contraception will NOT affect an existing pregnancy (i.e. is NOT an abortion pill) and will not affect future fertility.
- Offer emergency contraception.

CDC MMWR STI 2021 Updates Summary

- An updated table: “Implications of commonly encountered sexually transmitted or sexually associated infections for the diagnosis and reporting of sexual abuse among infants and prepubertal children.” (The social significance of Trichomonas is now listed as diagnostic for abuse if postnatally acquired and herpes is now listed as suspicious).
- When testing for HIV and syphilis after sexual assault, if initial tests are negative and infection in the assailant cannot be ruled out, serologic tests for syphilis can be repeated in 4-6 weeks and 3 months and HIV testing can be repeated at 6 weeks and 3 months.
- HPV vaccination is recommended for female and male sexual assault survivors ages 9-26 years who have not been vaccinated or are incompletely vaccinated.
- Testing for T. vaginalis should not be limited to girls with vaginal discharge if other indications for vaginal testing exist because evidence indicates that asymptomatic sexually abused children might be infected with T. vaginalis and might benefit from treatment. NAAT can be used for diagnosis, especially in situations in which culture and wet mount of vaginal swab specimens are not obtainable, however, only CLIA-validated, FDA-cleared NAATs should be used. POC tests for T. vaginalis have not been validated for prepubertal children and should not be used. In the case of a positive specimen, the result should be confirmed either by retesting the original specimen or obtaining another.
- When testing prepubertal children for gonorrhea and chlamydia with NAAT, only CLIA-validated, FDA-cleared NAAT assays should be used. All positive results should be confirmed.

Implications of commonly encountered sexually transmitted or sexually associated infections for diagnosis and reporting of sexual abuse among infants and prepubertal children

Infection	Evidence for sexual abuse	Recommended action
Gonorrhea*	Diagnostic	Report†
Syphilis*	Diagnostic	Report†
HIV§	Diagnostic	Report†
*Chlamydia trachomatis**	Diagnostic	Report†
*Trichomonas vaginalis**	Diagnostic	Report†
Anogenital herpes	Suspicious	Consider report†,¶
Condylomata acuminata (anogenital warts)*	Suspicious	Consider report†,¶,**
Anogenital molluscum contagiosum	Inconclusive	Medical follow-up
Bacterial vaginosis	Inconclusive	Medical follow-up

Sources: Adapted from Kellogg N; American Academy of Pediatrics Committee on Child Abuse and Neglect. The evaluation of child abuse in children. Pediatrics 2005;16:506–12; Adams JA, Farst KJ, Kellogg ND. Interpretation of medical findings in suspected child abuse: an update for 2018. J Pediatr Adolesc Gynecol 2018;31:225–31.

* If unlikely to have been perinatally acquired and vertical transmission, which is rare, is excluded.

† Reports should be made to the local or state agency mandated to receive reports of suspected child abuse or neglect.

§ If unlikely to have been acquired perinatally or through transfusion.

¶ Unless a clear history of autoinoculation exists.

** Report if evidence exists to suspect abuse, including history, physical examination, or other identified infections. Lesions appearing for the first time in a child aged >5 years are more likely to have been caused by sexual transmission.

Children and Adolescents who Experience Sexual Assault/Abuse Need A Community Response To Address Their Trauma

- While this protocol addresses the initial medical needs of the child, best practices encourage comprehensive evaluation, assessment, and treatment of child sexual assault/abuse in collaboration with community partners, including investigative agencies, child protective agencies, prosecutors, multidisciplinary teams, healthcare providers, child advocacy centers, and victim advocacy agencies. Furthermore, "collaboration across disciplines enhances the quality of health care, improves the quality of forensic evidence, increases law enforcement's ability to collect information, file charges, and refer an investigation to prosecution, and increases prosecution rates(U.S Department of Justice, 2017)."

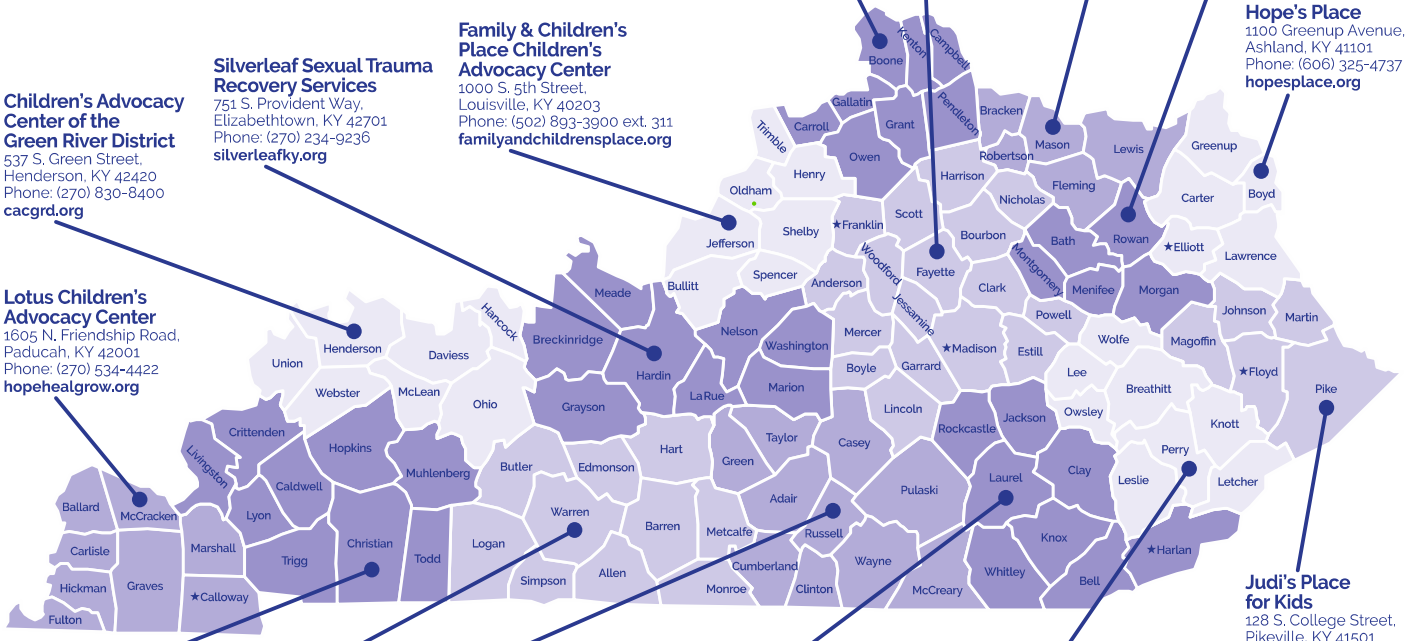
Follow up

- Provide the caretaker and patient with the contact information for the Children's Advocacy Center in their region (https://cackentucky.org/local-centers). The Children's Advocacy Center can provide victim advocacy, counseling, and/or serve as a resource for where to obtain these services.

Children's Advocacy Centers of Kentucky

For more information on each CAC, see www.cackentucky.org

- ● Main Office
- ★ Satellite Office
  Please contact main office for information about satellite office coverage in this service area.



Northern Kentucky Children's Advocacy Center
4890 Houston Road,
Florence, KY 41042
Phone: (859) 442-3200
nkycac.org

Buffalo Trace Children's Advocacy Center
224 Limestone Street,
Maysville, KY 41056
Phone: (606) 563-0572
btcac.org

Children's Advocacy Center of the Bluegrass
162 N. Ashland Avenue,
Lexington, KY 40502
Phone: (859) 225-5437
kykids.org

Gateway Children's Advocacy Center
310 E. Main Street,
Morehead, KY 40351
Phone: (606) 780-7848
gatewaycac.com

Hope's Place
1100 Greenup Avenue,
Ashland, KY 41101
Phone: (606) 325-4737
hopesplace.org

Family & Children's Place Children's Advocacy Center
1000 S. 5th Street,
Louisville, KY 40203
Phone: (502) 893-3900 ext. 311
familyandchildrensplace.org

Silverleaf Sexual Trauma Recovery Services
751 S. Provident Way,
Elizabethtown, KY 42701
Phone: (270) 234-9236
silverleafky.org

Children's Advocacy Center of the Green River District
537 S. Green Street,
Henderson, KY 42420
Phone: (270) 830-8400
cacgrd.org

Lotus Children's Advocacy Center
1605 N. Friendship Road,
Paducah, KY 42001
Phone: (270) 534-4422
hopehealgrow.org

Judi's Place for Kids
128 S. College Street,
Pikeville, KY 41501
Phone: (606) 437-7447
judisplace.org
Floyd Co. Satellite Office Phone:
(606) 886-8520

Kentucky River Children's Advocacy Center
465 Cedar Street,
Hazard, KY 41701
Phone: (606) 487-9173
carecottage.org

Cumberland Valley Children's Advocacy Center
1130 E. 4th Street,
London, KY 40741
Phone: (606) 878-9116
cv-cac.org
Harlan Co. Satellite Office Phone:
(606) 621-5228

Lake Cumberland Children's Advocacy Center
427 S. Main Street,
Jamestown, KY 42629
Phone: (270) 343-6922

Pennyrile Children's Advocacy Center
1102 E. 21st Street,
Hopkinsville, KY 42240
Phone: (270) 881-1111
pennyrilecac.org

Barren River Area Child Advocacy Center
103 E. 12th Street,
Bowling Green, KY 42101
Phone: (270) 783-4357
bracac.org


Children's
Advocacy
Center
of the Bluegrass
162 North Ashland Ave.


465
Care
Cottage

Child Friendly Environment

Medical Examinations Are Sometimes Necessary at the CAC after the Child was seen by another Healthcare Provider

- Obtain clinical photography for an abnormal finding or injury that was identified
- Assess healing of an injury
- Clarify an unclear finding
- Reassess a finding that was identified by an inexperienced examiner
- Provide the patient with STI testing results and perform additional STI testing if necessary
- Discuss and the results of the medical exam that occurred outside of the CAC with the patient
- Prescribe additional HIV nPEP to complete a full 28 day course
- Monitor adherence with treatment recommendations
- Address patient's mental health
- Assess the patient's continued safety

Follow Up after Discharge

- Follow up serologic testing for syphilis and HIV should be repeated at 12 weeks after the assault.
- Complete Hepatitis B immunization as indicated if child is not previously immunized or serology indicates need for a booster dose.
- Follow up pregnancy testing should be provided if child misses a menstrual period.
- Follow up with infectious disease specialist if HIV nPEP is provided.
- Recommend HPV vaccination if child is greater or equal to age 9 and has not yet received this vaccination.

Gavril A, Kellogg N, and Nair P. (2012). Value of follow-up examinations of children and adolescents evaluated for sexual abuse and assault. Pediatrics, 129:282-289.

- 727 patients
- Follow up examination resulted in a change in interpretation of trauma likelihood in 129 (17.7%) patients and identified STIs in 47 (6.5%) patients.
- Changes in trauma likelihood and detection of additional STIs during follow-up examinations were more likely in adolescent, female, and sexually active patients and those with a history of genital–genital contact, unknown examination 1 findings, or drug-facilitated sexual assault.
- Although examination 2 was less likely to affect the interpretation of trauma likelihood and STIs in preadolescent patients, a change in interpretation of trauma likelihood was noted for 49 (15.5%) of these patients, and 16 (5.1%) were diagnosed with a new STI on examination 2.
- The level of clinician experience during examination 1 did affect the likelihood of changes in examination findings during examination 2.

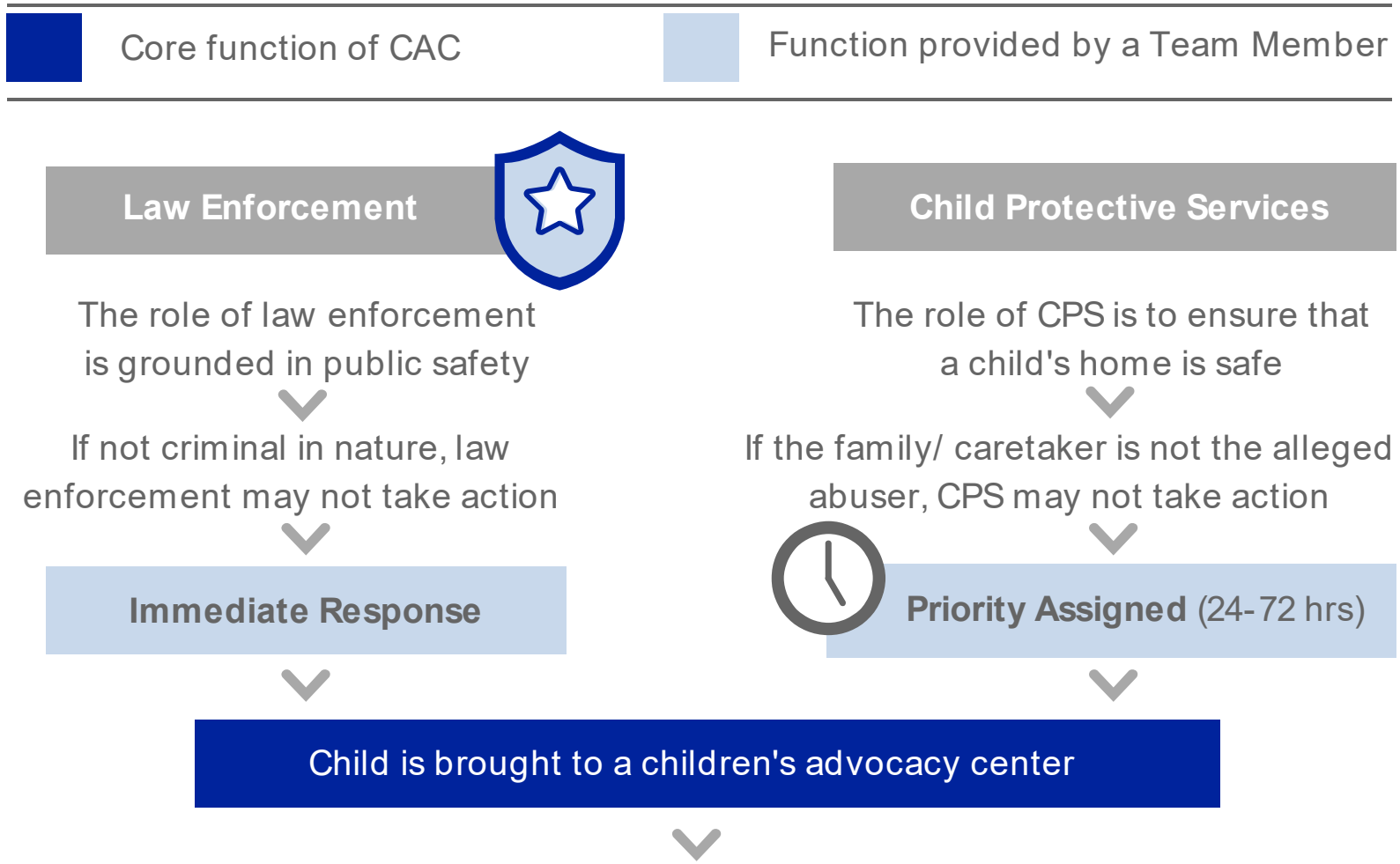
Gavril findings

- STIs identified at follow-up were: condylomata acuminata (n = 34), chlamydia (n = 10), trichomonas (n = 1), gonorrhea (n = 1), and secondary syphilis (n = 1)
- Although changes in diagnosis and treatment from exam 1 to 2 primarily affected patients who were female, adolescent, sexually active, or who had a history of genital to genital contact or DFSA, changes on follow-up examination were also noted among preadolescents, males, and those with no history of penetrative trauma

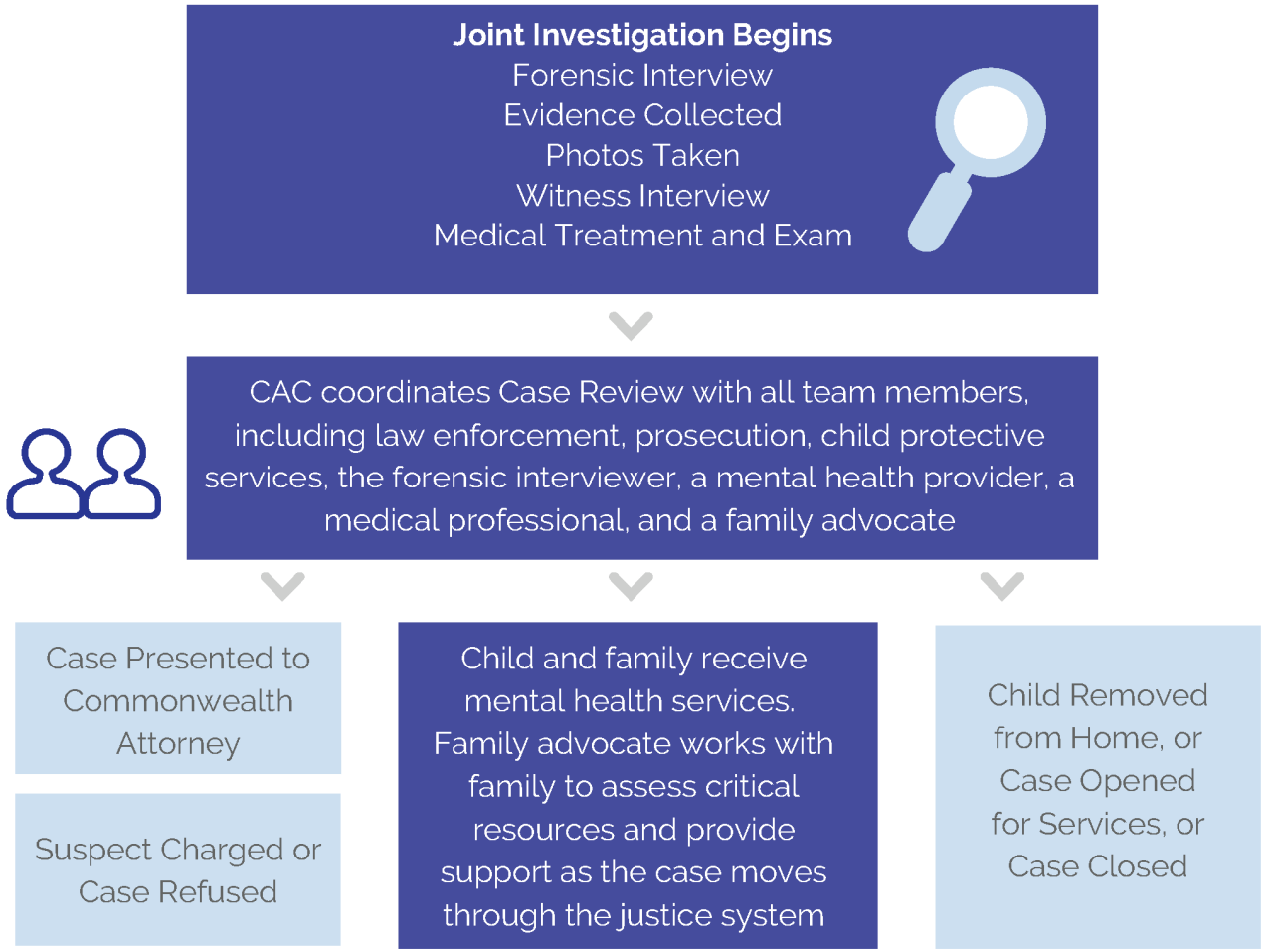
Discharge Planning and Follow-Up

- Consult a pediatrician or pediatric child abuse specialist (refer to the https://cackentucky.org/medical-resources) to discuss patient management if there are questions.
- Validate the child's feelings by acknowledging that sexual assault/abuse disclosures are difficult to make and take courage. Remind the child that they may need to share their story with individuals responsible for keeping them safe at a later date.
- Review what was done during the evaluation (exam findings, tests ordered, and what follow up care is needed) with the patient and caregiver. Sample form available at https://cackentucky.org/medical-resources.
- Ensure that all immediate medical and mental health needs are addressed.
- Consider providing an antiemetic if emergency contraception and/or STI prophylaxis/treatment is provided. Educate patients/caregivers that if medications are vomited following facility discharge, the facility should be contacted for further guidance.
- In reported cases, tell the caretaker that investigators request that the caregiver avoid questioning the child about the assault/abuse. The investigators should schedule the child to be interviewed by a trained child forensic interviewer at a Children's Advocacy Center. This provides the child the opportunity to tell what happened. If a child spontaneously discusses the sexual assault/abuse with a caregiver, it is okay to listen.
- Ensure that the child will be discharged to a safe environment.
  - Await safe disposition/DCBS recommendations prior to discharging the patient if applicable
  - KRS 620.040(5) (b) provides authority to physicians and hospital administrators to place a child under a 72-hour hold if necessary for protection of the child.

How it works: The CAC Model in Kentucky



How it works: The CAC Model in Kentucky - Continued



Save the Date

What: **Sexual Assault Nurse Examiner – Pediatric/Adolescent (SANE- P/A) Didactic Course** ***

Pending Kentucky Board of Nursing Approval***

When: **0800-1700, October 26-29, 2021 and November 1, 2021**

Where: **Via zoom**

Expected Cost: **$250**

If interested or for more information, contact Anita Capillo, RN, BSN, SANE A/A, Course Administrator, at kyforensicrn@gmail.com

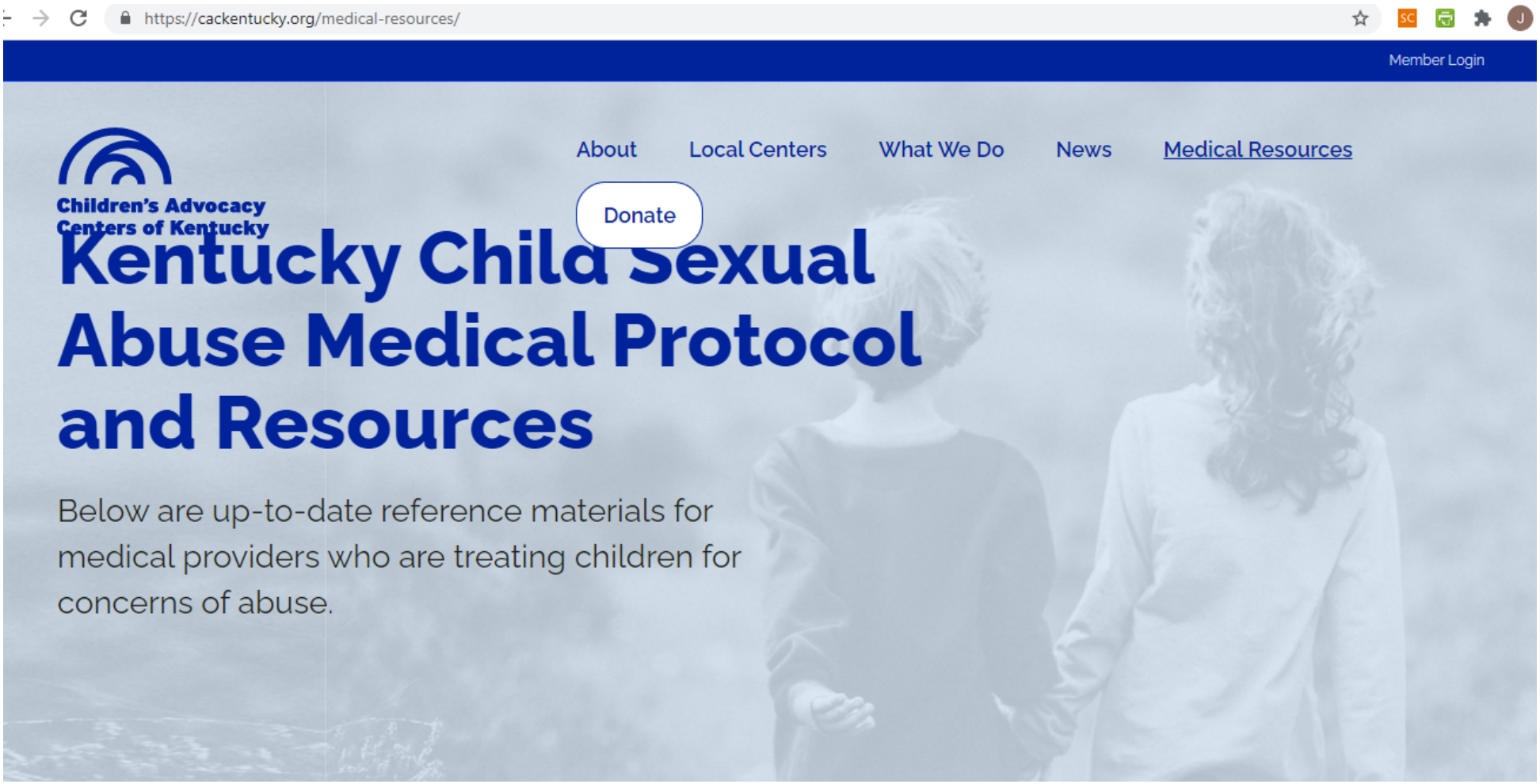
Presented as a result of a statewide and multidisciplinary collaboration with representatives from University of Kentucky/University of Louisville/Kosair Charities/Children's Advocacy Centers of Kentucky/Kentucky State Police Central Forensic Laboratory/Lexington SANE/Fayette Commonwealth's Attorney's Office/Hardin SANE/Louisville SANE Program.

Board-certified child abuse pediatricians in the Commonwealth are available for phone consultation. In addition, they provide formal consultations and medical expertise on the diagnosis, documentation, and follow up of suspected cases of child maltreatment.

- **The Norton Children's Pediatric Protection Specialists**, affiliated with the U of L School of Medicine, provide assessments in Louisville and Southern Indiana, as well as for all 120 counties in Kentucky. Norton Children's Pediatric Protection Specialists are healthcare providers for the children assessed at the CAC in Louisville.
- https://nortonchildrens.com/services/pediatric-protection/services/
- Team members are available 24/7.
- (502)629-6000.
-
- **The University of Kentucky Division of Pediatric Forensic Medicine** provides assessments in Lexington as well as central and eastern Kentucky. UK PFM providers deliver care to the children assessed at CAC Bluegrass.
- https://ukhealthcare.uky.edu/kentucky-childrens-hospital/services/support-services/forensic-medicine
- On call phone consultation is available 24/7.
- Weekdays 0800-1600: (859)218-6727
- Evenings, weekends, and holidays: (859)257-5522 (ask for the Pediatric Forensic Medicine Provider on call)

Medical Websites

- https://cackentucky.org/medical-resources


https://cackentucky.org/medical-resources/
Member Login
Children's Advocacy Centers of Kentucky
About
Local Centers
What We Do
News
Medical Resources
Donate
Kentucky Child Sexual Abuse Medical Protocol and Resources
Below are up-to-date reference materials for medical providers who are treating children for concerns of abuse.

Dr. Sugarman Contact Information

- Jsuga2@uky.edu
- Drsugarman@kykids.org
- UK MD's 859-257-5522

Take Home Pearls

- Sexual abuse is not uncommon.
- A detailed history from the caretaker should be obtained separate from the child.
- A history using developmentally appropriate terminology/language should be obtained from the child separate from the caretaker.
- The components of the exam and consent/assent should be discussed and obtained prior to the examination.
- The medical exam is one of many stops on the journey to healing.
- Children who present acutely should have a detailed exam to assess for injury and infection and collection of evidence based on the history.
- **The majority of sexual abuse exams will be normal or nonspecific (There are classifications of findings available to assess the significance of a finding or of an infection). A NORMAL EXAM CAN NEITHER CONFIRM NOR DISCOUNT ABUSE.**

Take Home Pearls

- Children will benefit from follow up by a medical provider with experience in the evaluation and management of children who have experienced sexual assault/abuse.
- Children's Advocacy Centers provide advocacy, mental health support, medical support and follow up and forensic interviews.
- Every community has resources to help survivors of sexual abuse heal.
- There are resources for providers available (websites, phone, clinical pathway guidelines).
- **Report all <u>suspected</u> abuse to the Child Abuse Hotline and the police.**

References

- Workowski KA, Bachmann LH, Chan PA, et al. Sexually transmitted infections treatment guidelines, 2021. *MMWR Recomm Rep*. 2021;70(No. RR-4):1–187. DOI: http://dx.doi.org/10.15585/mmwr.rr7004a1.
- American Academy of Pediatrics. *Red Book: 2021–2024 Report of the Committee on Infectious Diseases.* 32nd ed. American Academy of Pediatrics; 2021.
- https://cackentucky.org/medical-resources
- Christian et. al. Forensic findings in prepubertal victims of sexual assault. Pediatrics 2000; 106:100-104.

References

- https://www.nctsn.org/resources/pediatric-medical-traumatic-stress-toolkit-health-care-providers.
- McCann J, Miyamoto S, Boyle C, Rogers K. Healing of hymenal injuries in prepubertal and adolescent girls: a descriptive study. Pediatrics 2007; 119:e1094-e1106.
- McCann J, Miyamoto S, Boyle C, Rogers K. Healing of nonhymenal injuries in prepubertal and adolescent girls: a descriptive study. Pediatrics 2007; 120:1000-1011.