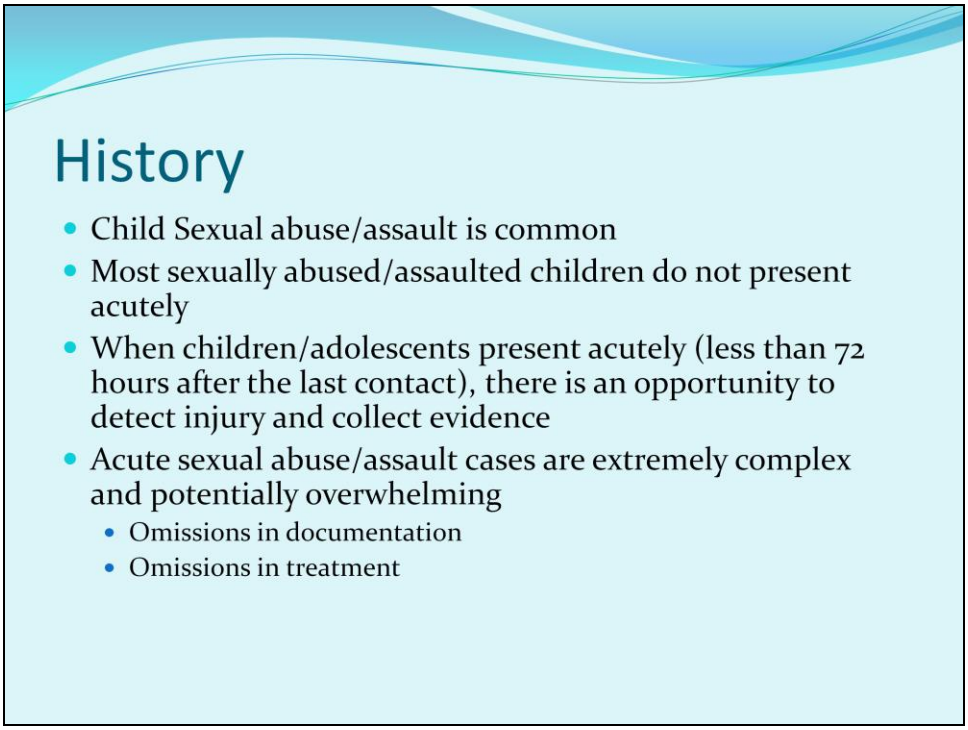
The SA Pocket Tool
Session 1

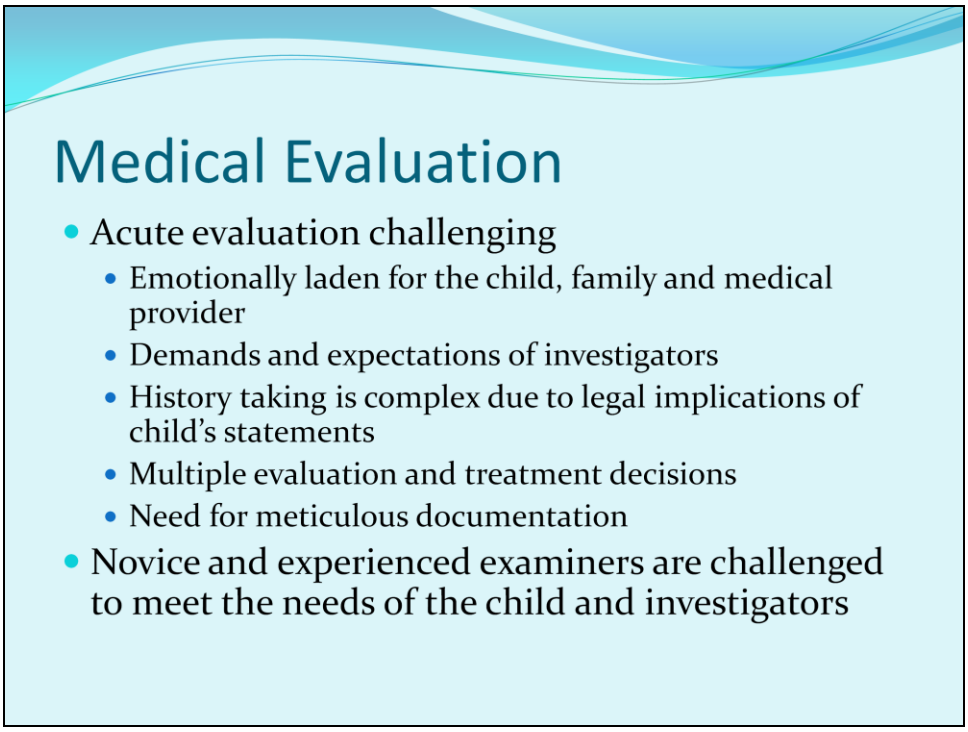
Orientation to the topic and tool



Child sexual abuse is a serious national problem affecting both teens and younger children. National data indicate that teenagers have the highest rate of sexual assaults of any group with a rate of 3.5% for teens 12 through 15 years of age and 5% for those ages 16 to 19 years.[1]

Children under the age of 12 years present for care after disclosing acute child sexual abuse/assault, but the rate in this age group is less clear. Pediatricians who evaluate children and adolescents should be knowledgeable about evaluation and treatment of sexual assault victims.

[1]Reference: American Academy of Pediatrics, Committee on Adolescence. Sexual assault and the adolescent. *Pediatrics.* 2001;107(6):1476-79



The medical evaluation of children suspected of being acutely (i.e., in the previous 72 hours) sexually abused by a caregiver or assaulted by a non-caregiver is a very complex process involving multiple decisions dictated by case-specific information collected in an emotionally-charged, high-stress clinical setting. This poses unique documentation and treatment challenges for clinicians in these situations. Since the medical record is a legal document used by law enforcement and child protective service investigators, medical history, physical exam and collection of specimens must be meticulous.

While taking the medical history, the provider must elicit all information necessary for medical decision-making with minimum interviewing. Interviewing should be kept to a minimum to allow investigators to pursue a less traumatic forensic interview at a child-friendly setting. This detailed interview may be obtained by an expert interviewer in a Child Advocacy Center setting or in another setting by the most experienced person possible. The interview of the child is critical not only for medical reasons, but also constitutes legal evidence that may be used in the investigation. By choosing the most qualified professional to interview the child, one can minimize further trauma to the child through repetition of the events. Depending on local guidelines, the interview may be videotaped and shared with other professionals who need that information.

The physical exam must be detailed in scope and tailored to specifics of the history, yet sensitive both to the emotional needs of the child and the need to document and collect evidence.

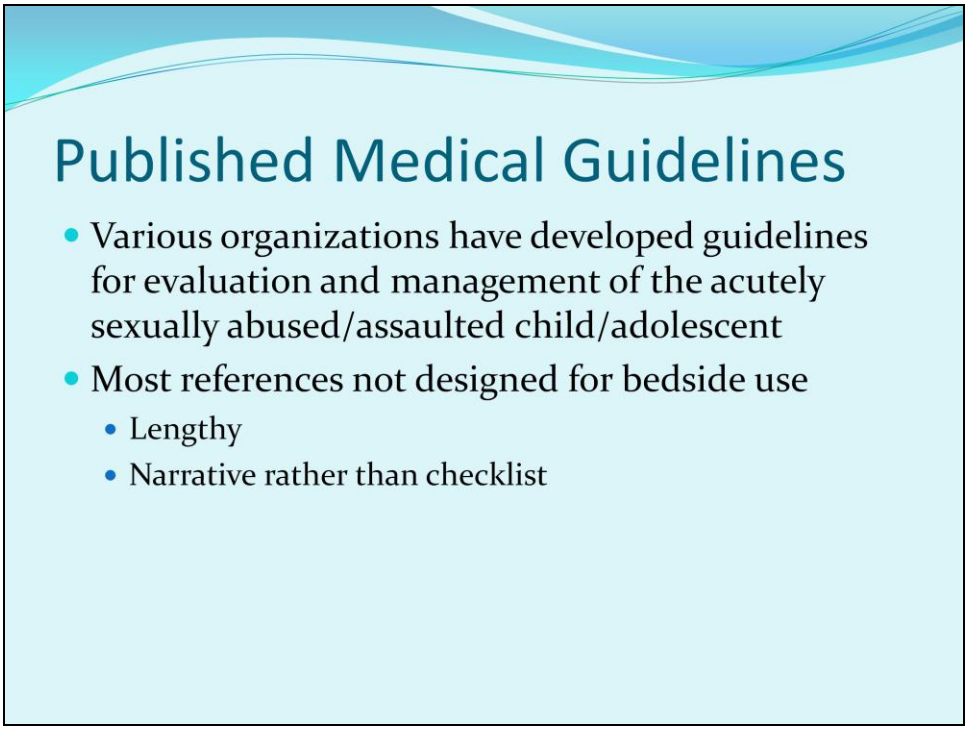
Diagnostic decisions are complex and largely dependent on a history that is often incomplete at first disclosure. Treatment decisions, such as sexually transmitted infection (STI), HIV and pregnancy prophylaxis, are complicated because these patients, particularly adolescents, are often lost to follow up.

If the medical evaluation is carefully performed and documented through the use of a checklist, patient care can be improved and the record becomes an invaluable tool when testimony is required. Detailed documentation may even preclude the health care provider from having to testify in court.

References:

Hanes M, McAuliff T. Preparation for child abuse litigation: perspectives of the prosecutor and the pediatrician. *Pediatr Ann.* 1997;26:288-295

Baron ME, Zanga JR. Child abuse: a model for the use of structured clinical forms. *Pediatrics.* 1996;98:429-233



Various organizations have attempted to simplify and standardize sexual assault evaluations through the publication of protocols; however, the resulting documents have been unwieldy and are seldom used. The 134 page American College of Emergency Physicians protocol published in 1999 and the 129 page National Sexual Assault Protocol published in 2004 are often "filed" at clinical sites and not readily available or useful when children or teens present following an acute sexual assault. As a consequence, documentation and appropriate decision-making in these complex evaluations may be compromised because the clinician must remember and appropriately perform all aspects of the complex standard examination.

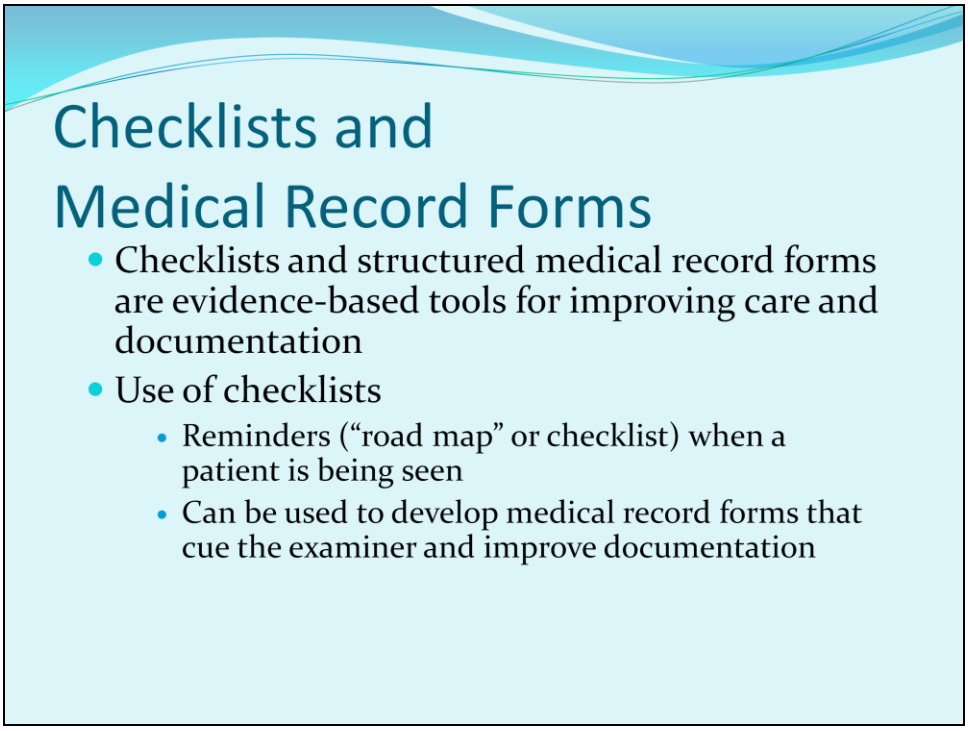
Many hospitals have tried to improve care of these patients by employing Sexual Assault Nurse Examiners or advanced practice providers such as nurse practitioners or physician assistants with additional training and expertise in managing these patients. However, even with this specialized training, clinicians have difficulty navigating these complex evaluations while maintaining consistent quality of care and documentation. For example, there are deficits in compliance with STI diagnosis and post-exposure prophylaxis guidelines in emergency departments.

References:

American College of Emergency Physicians. Evaluation and Management of the Sexually Assaulted or Sexually Abuse Patient. Dallas, TX: American College of Emergency Physicians; 1999. Available at: http://www.acep.org/library/index.cfm/id/2101. Accessed October 16, 2006

U.S. Department of Justice, Office on Violence Against Women. A National Protocol for Sexual Assault Medical Forensic Examinations (2004 September). Available from: http://www.ncjrs.org/pdffiles1/ovw/206554.pdf. Accessed on October 16, 2006

Kane BG, Degutis LC, Sayward HK, D'Onofrio G. Compliance with the Centers for Disease Control and Prevention Recommendations for the Diagnosis and Treatment of Sexually Transmitted Diseases. *Academic Emergency Medicine* 2004;11:371-377



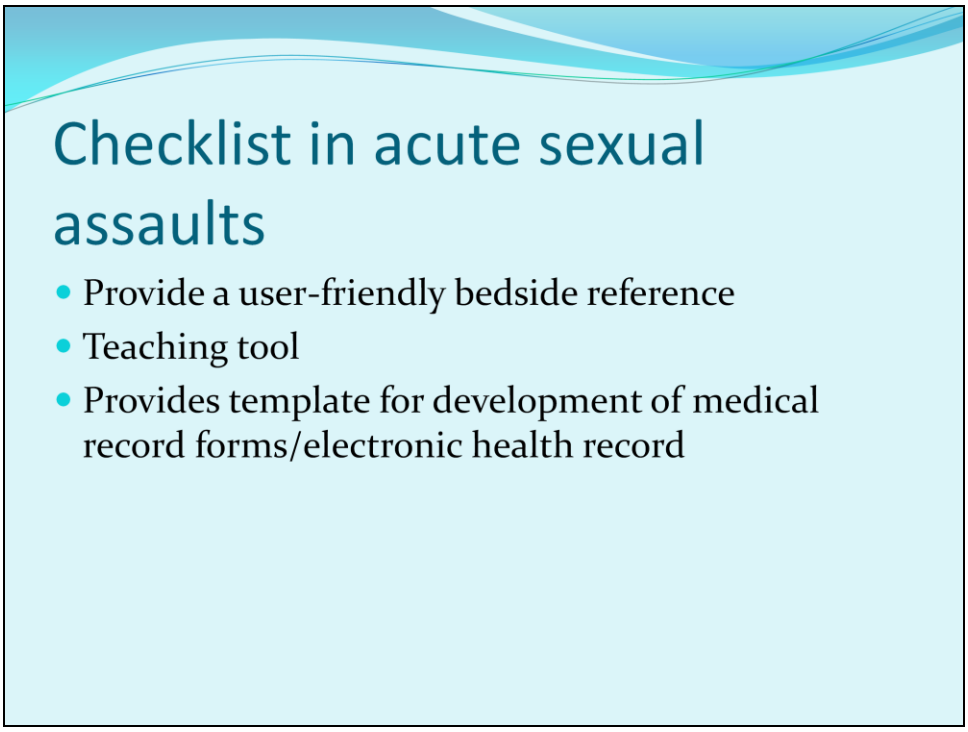
There has been very little previous research with a focus on improved documentation and quality of care for the acutely sexually abused/assaulted child. Davis (1995) found that reminders, such as a pocket reference checklist, combined with other strategies were the most effective interventions in improving physician performance and health care outcomes. Socolar, in 1998, used case-specific feedback to physicians to try to improve documentation and knowledge in child sexual abuse cases. There was no improvement that could be attributed to this time-intensive intervention.

The most successful approaches are user-friendly, readily available and utilized by an experienced and specially trained examiner. While structured medical record forms have been shown to improve documentation, while requiring little additional motivation or work for those who are evaluating the child, they are difficult to use in acute child sexual abuse/assault because the evaluation must be tailored to the age of the child and the specifics of the history.

References:

Davis DA, Thomson MA, Oxman AD, Haynes RB. Changing physician performance: a systematic review of the effect of continuing medical education strategies. *JAMA.* 1995;274:700-705

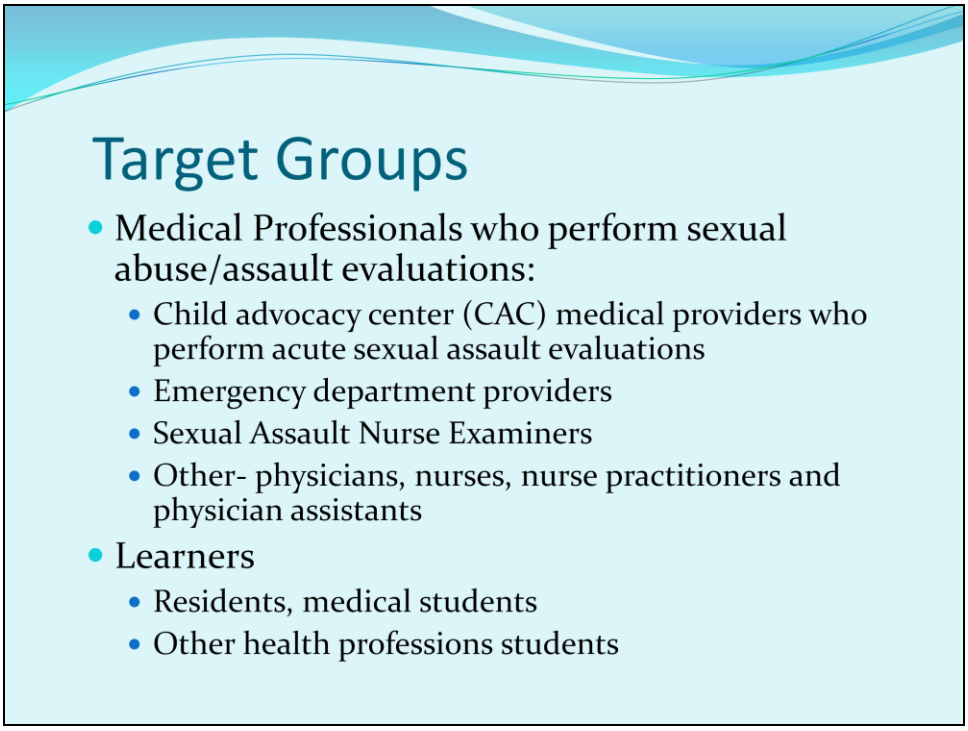
Socolar RR, Baines B, Chen-Mok M, Runyan DK, Green C, Paterno S. Intervention to Improve Physician Documentation and Knowledge of Child Sexual Abuse: A Randomized, Controlled Trial. *Pediatrics.* 1998;101:817-824



The SA Pocket Tool is based on nationally recognized standards and protocols however it cannot replace medical judgment. It was developed as a thorough reminder and prompt during or before the evaluation of the child who is suspected of being acutely sexually abused or assaulted. The tool may be used as a checklist during an evaluation or as a refresher tool immediately before evaluation.

A pocket reference checklist that delineates key elements of the medical history, physical exam, diagnostic tests and treatment options may improve documentation, adherence to standards of care and quality of care by health care providers in the emergency room and other medical settings in cases of children who have been acutely sexually abused/assaulted. In these settings, the tool may be used to educate learners at all levels.

The tool is also a helpful resource in developing standard medical documentation templates, in paper or electronic format, to ensure that key elements of the evaluation are captured for documentation and billing purposes.



The tool is a useful resource for providers who vary from inexperienced to very experienced. It was developed specifically for emergency department providers who have some experience in evaluating sexual assaults but do so infrequently. A more experienced provider can use the tool as a reminder checklist and a less experienced provider can use it to help guide the evaluation. The tool is not meant to be used as a "how to" manual for sexual assaults in pediatric patients.

A novice provider or a learner could also refer to more in-depth resources such as the American College of Emergency Physicians guidelines if more detail is desired.

Use of the Tool

- Purpose
  - Refresher/checklist- for more experienced providers
  - Guide- Use throughout the evaluation for less experienced providers
- SA Pocket Tool
  - 6.5x4 inches Four-fold tool

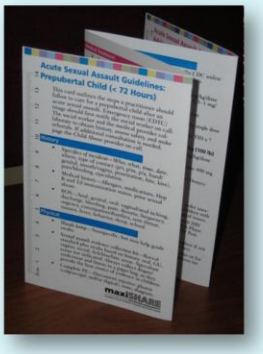
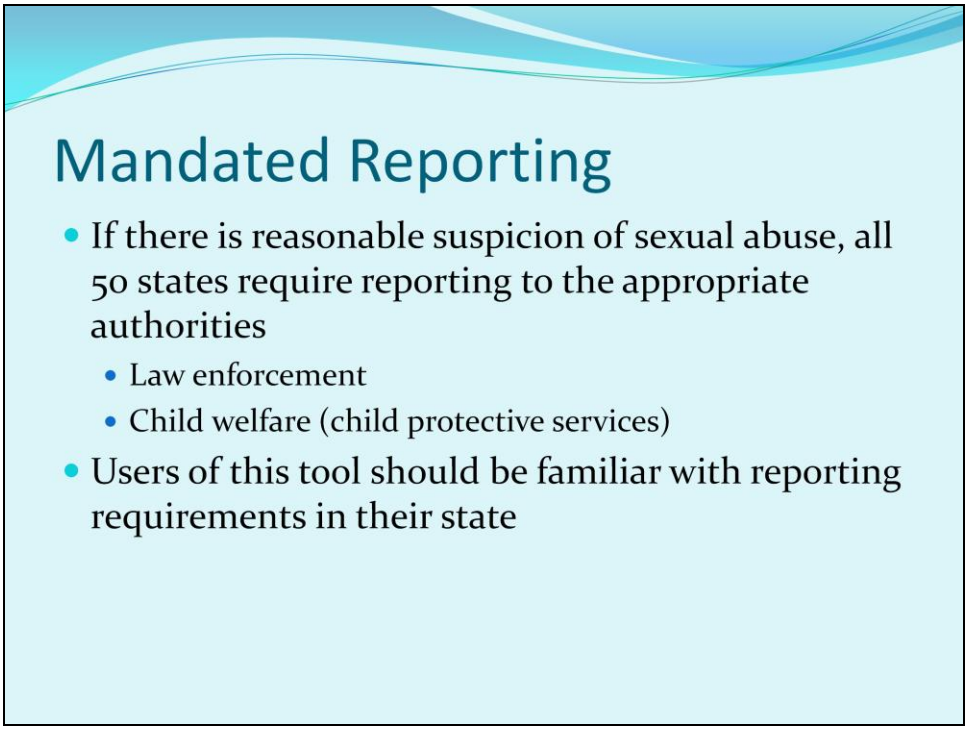


Photo - Owned by and provided with permission of Lynn K. Sheets, MD

Providers and learners will both find the tool useful. It is a handy checklist for experienced providers and a sequential guide for those who are less experienced at performing child/adolescent acute sexual assault evaluations. The attendees should now turn to their tool to become more acquainted with it.

The tool may be printed at Children's Hospital of Wisconsin's maxiSHARE if the user would like to have a Four-fold pocket tool with local resources (for a fee). An alternative is that the tool may be printed from the MedEdPORTAL website and used as a 2-page reference.



A reminder about mandated reporting is needed. As all providers should know, if there is reasonable suspicion of child maltreatment including acute sexual assault or acute sexual abuse involving a minor, a report should be made to appropriate authorities, usually law enforcement and child protective services. All 50 states require reporting of suspected child maltreatment including child sexual abuse and assault.

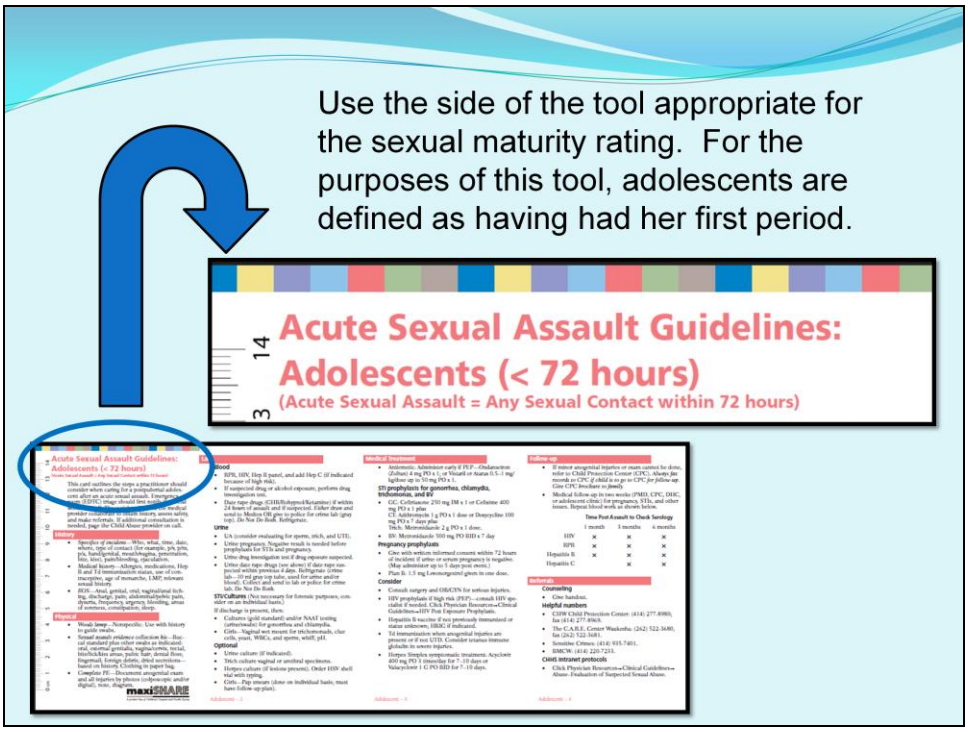
For reference and links to resources refer to:

Brown, J. Physicians have ethical, legal obligation to report child abuse. *AAP News* 2012;33(3) accessed 3/7/12 on line at http://aapnews.aappublications.org/content/33/3/20.1.full

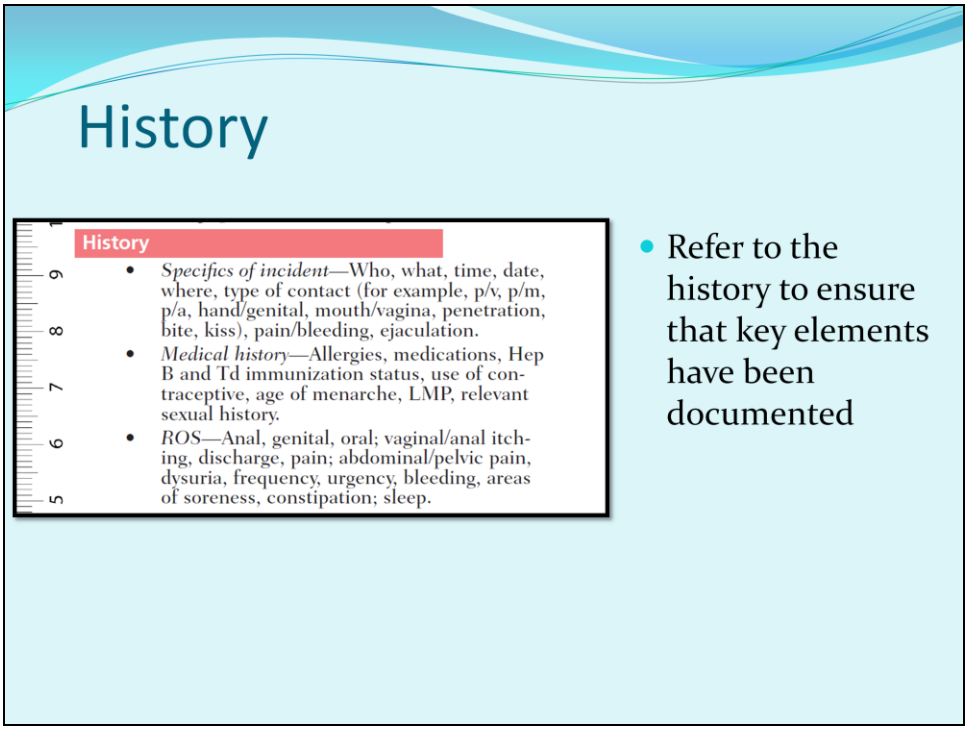
Gilbert R, et. al. Recognising and responding to child maltreatment. *Lancet*.2009;373:167-80

Pre-pubertal Sexual Assaults

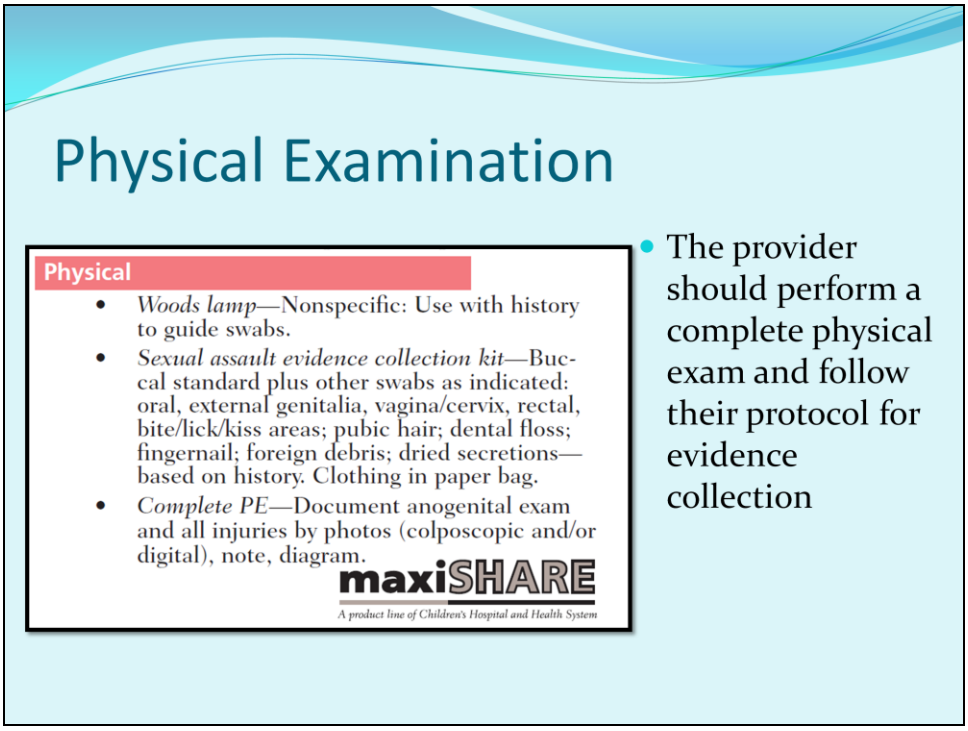
- Consider consulting your local experts for further guidance
- It is important to recognize that when the last episode was within 72 hours, it is considered acute even if the perpetrator has molested the child chronically



The tool is conveniently divided into 2 sections, adolescent and pre-pubertal, as the maturity of the child affects medical history, physical exam, diagnostic testing and treatment recommendations. For the purposes of this tool, an adolescent female is defined as a female child who is post-menarcheal.

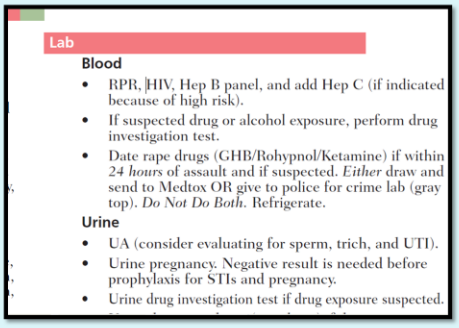


The tool is divided into standard sections regarding the medical history, physical exam and laboratory tests. The tool can help the provider to include key elements in each category.



A complete physical examination is indicated in sexual assaults involving children and teens. The provider should collect evidence as dictated by the standards in their state.

Diagnostic Studies



Lab

Blood

- RPR, HIV, Hep B panel, and add Hep C (if indicated because of high risk).
- If suspected drug or alcohol exposure, perform drug investigation test.
- Date rape drugs (GHB/Rohypnol/Ketamine) if within *24 hours* of assault and if suspected. *Either* draw and send to Medtox OR give to police for crime lab (gray top). *Do Not Do Both*. Refrigerate.

Urine

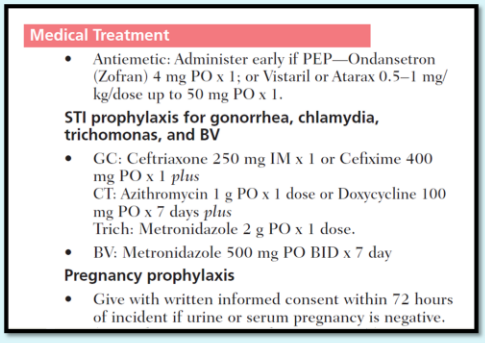
- UA (consider evaluating for sperm, trich, and UTI).
- Urine pregnancy. Negative result is needed before prophylaxis for STIs and pregnancy.
- Urine drug investigation test if drug exposure suspected.

- The lab portion of the tool will help guide the provider about studies to consider in acute sexual assaults involving adolescents

Before collecting labs, make sure you are aware of your local laboratory requirements about what specimen is needed and how the specimen is handled.

Some experts recommend treating prophylactically rather than obtaining initial cultures since cultures and Nucleic Acid Amplification Tests (NAATS) obtained after an assault could reflect material in the inoculum (semen)

Medical Treatment



Medical Treatment

- Antiemetic: Administer early if PEP—Ondansetron (Zofran) 4 mg PO x 1; or Vistaril or Atarax 0.5–1 mg/kg/dose up to 50 mg PO x 1.

STI prophylaxis for gonorrhea, chlamydia, trichomonas, and BV

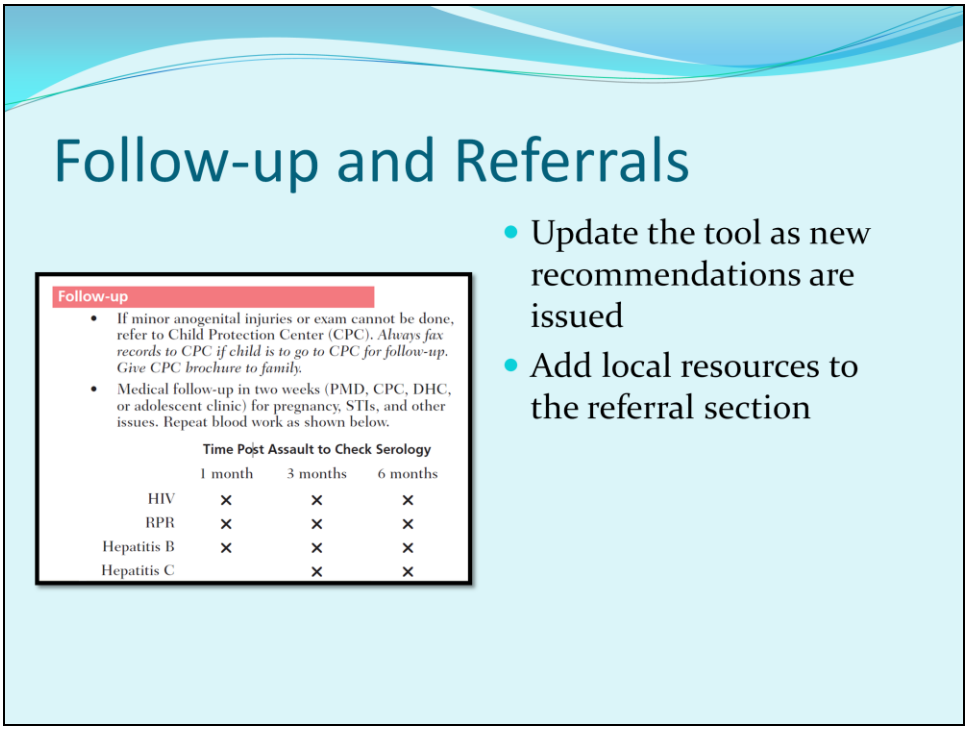
- GC: Ceftriaxone 250 mg IM x 1 or Cefixime 400 mg PO x 1 *plus*
  CT: Azithromycin 1 g PO x 1 dose or Doxycycline 100 mg PO x 7 days *plus*
  Trich: Metronidazole 2 g PO x 1 dose.
- BV: Metronidazole 500 mg PO BID x 7 day

Pregnancy prophylaxis

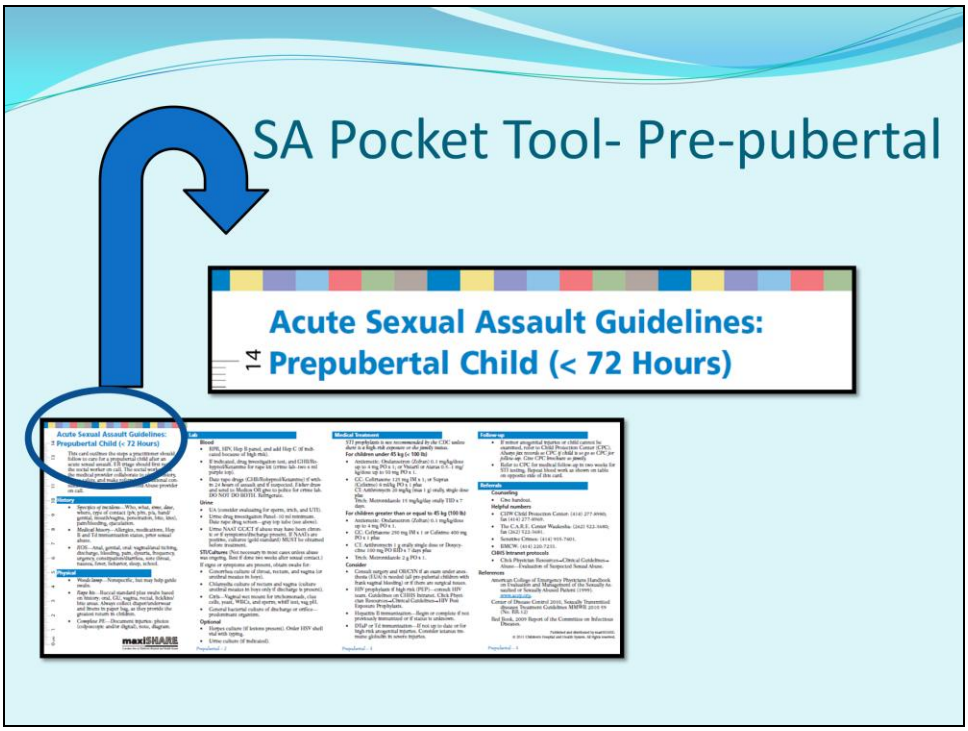
- Give with written informed consent within 72 hours of incident if urine or serum pregnancy is negative.

- Refer to CDC recommendations regarding antibiotics to use in PEP (post-exposure prophylaxis).
- Check the most recent recommendations- last updated in 2010

The medical treatment section consists of treatment considerations for an acutely sexually assaulted adolescent. The provider should check the Centers for Disease Control website or the most recent version of the MMWR STD Treatment Guidelines before providing antibiotics as the recommendations could change.



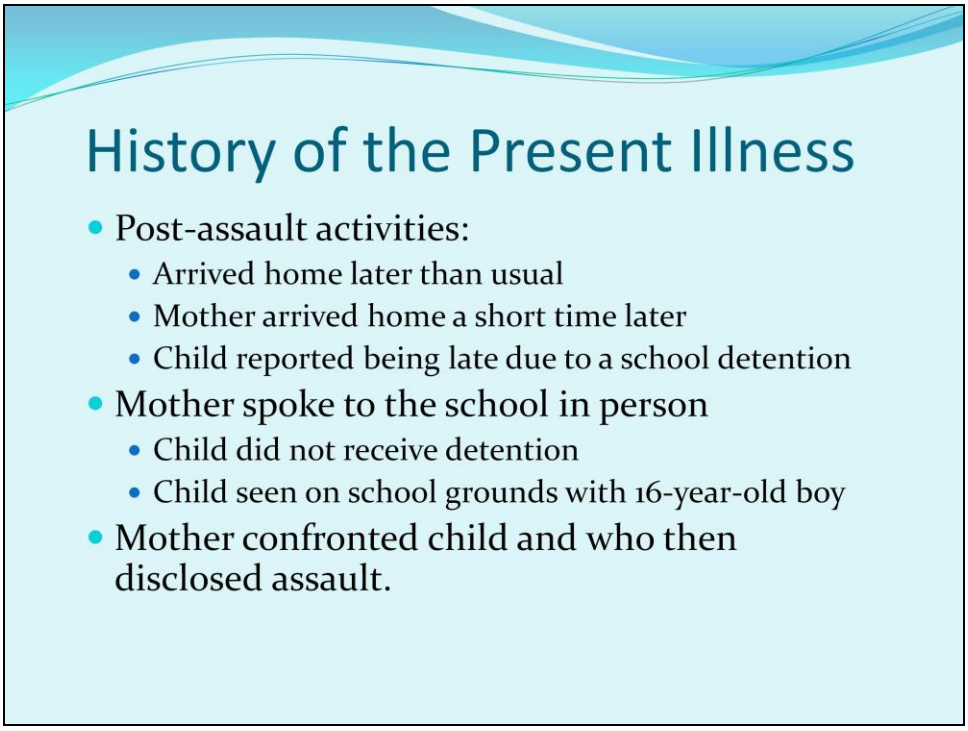
Follow up care is recommended including a referral to a Child Advocacy Center (CAC). The child or adolescent will also require repeat serologies after an acute assault. Local numbers can be inserted in the Referrals section of the tool.



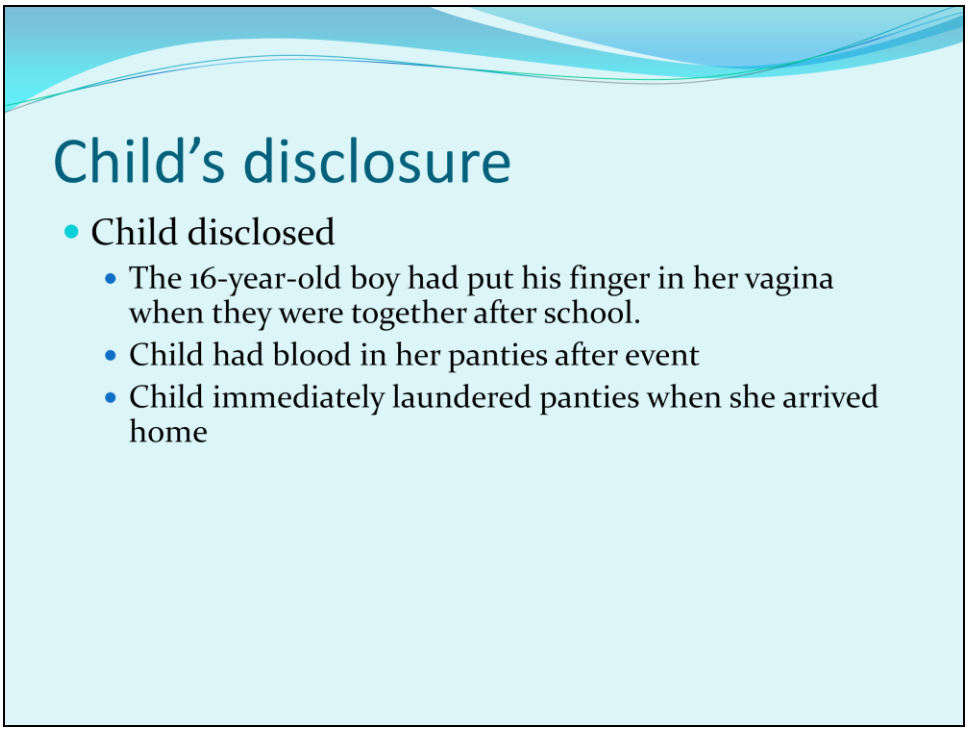
In the same way as the adolescent side of the tool, the pre-pubertal exam should be guided by the prompts on the tool. References for both sides of the tool are found on the pre-pubertal side.

Which tool does the provider use- adolescent or pre-pubertal?

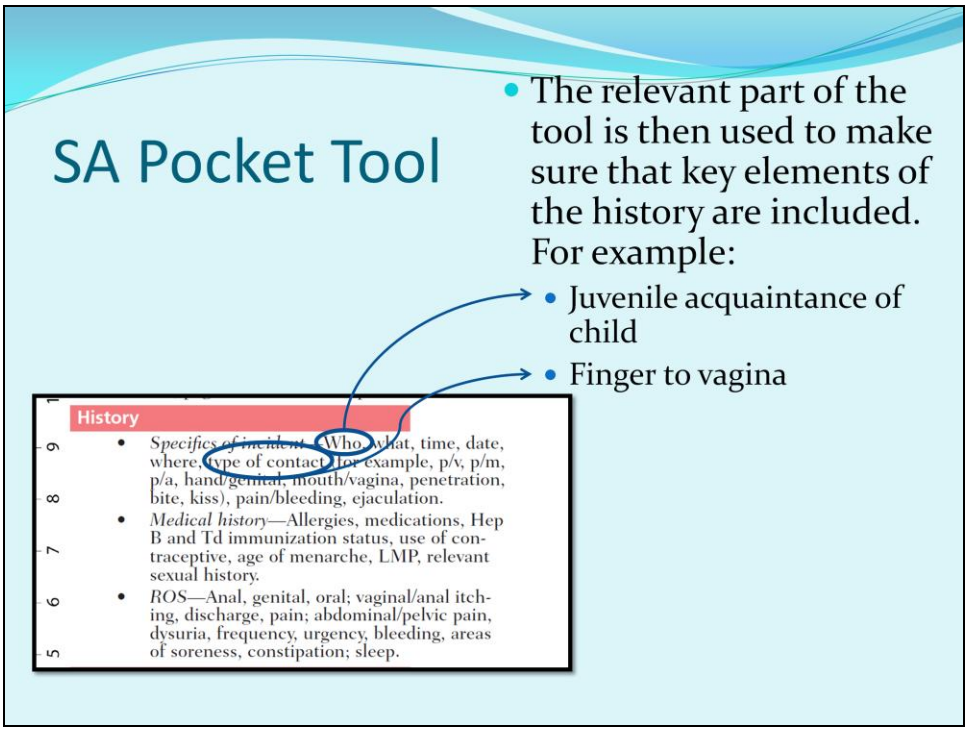
The girl started her periods a year ago, so the adolescent side of the tool should help guide the visit.



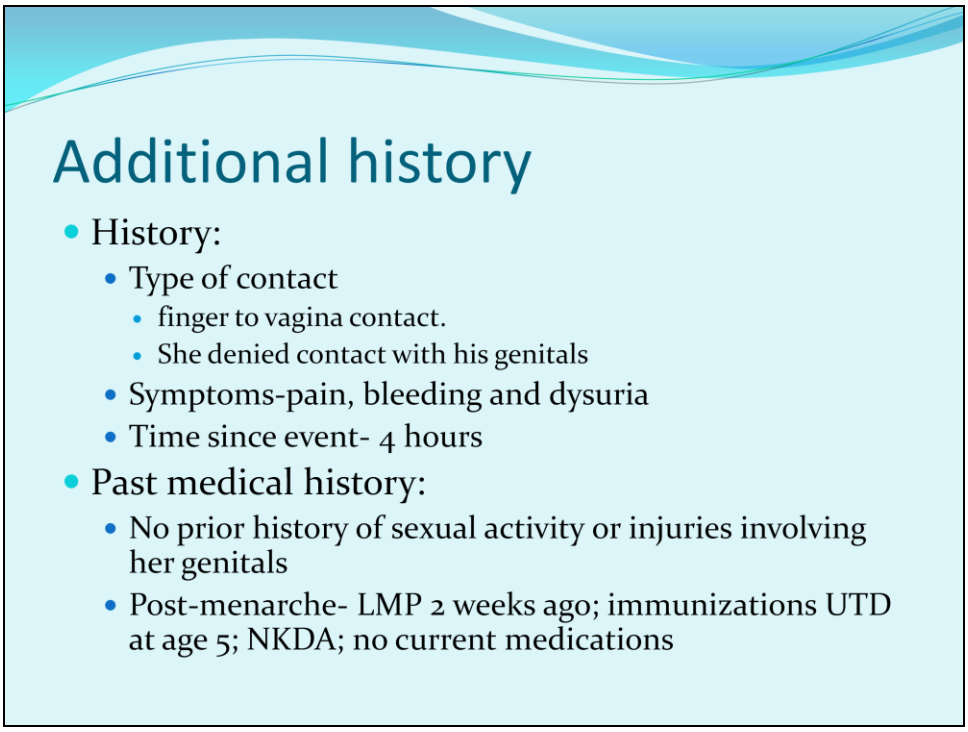
Are there other aspects of the HPI that the provider needs to know? Refer to the history section of the tool.



The child's disclosure is often the most important evidence in child sexual abuse/assault. It should be captured in the medical history accurately and using quotations as much as possible.



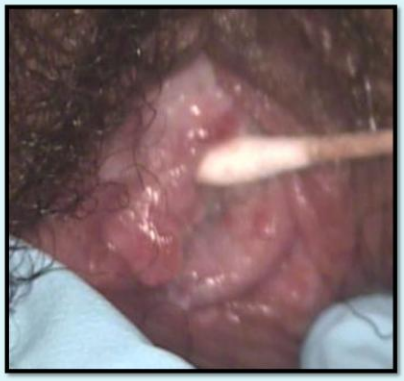
The tool is a useful way to make sure all of the key elements of the history are obtained.



Refer to the tool- is the history now complete? It is unknown if he ejaculated or licked his finger. Her PMH demonstrates there are no allergies, no current medications, no underlying medical conditions. Her immunizations are reportedly up to date except for the HPV vaccine. The family does not think she has received any shots since she was 4 or 5 years old. Her LMP was 2 weeks prior to this visit.

ROS- she denies any other symptoms other than vaginal spotting, moderate vaginal pain and slight dysuria.

Acute Exam



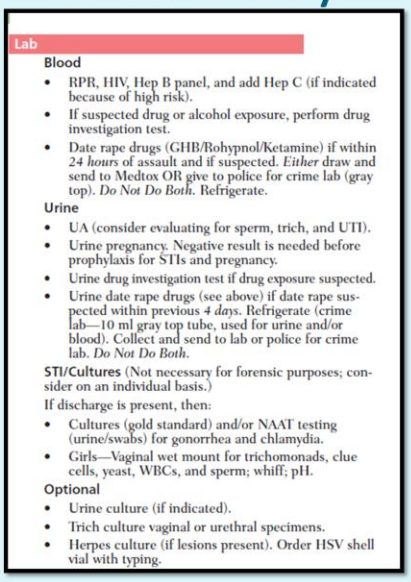
- Acute complete transection at about 6:00 Associated contusions
- For normal anatomy, refer to Berkoff M, Zolotor AJ, Makoroff KL et al. *JAMA*. 2008;300(23):2779-2792

Photo - Owned by and provided with permission of Lynn K. Sheets, MD

A Wood's lamp exam is negative for any areas of concern. A kit is collected and colposcopy shows this exam.

She has a Sexual Maturity Rating of 5 breast and genital. There is oozing of blood from 6:00-7:00 on the hymen in the supine position. The remainder of her complete head to toe exam is unremarkable.

Laboratory



Lab

Blood

- RPR, HIV, Hep B panel, and add Hep C (if indicated because of high risk).
- If suspected drug or alcohol exposure, perform drug investigation test.
- Date rape drugs (GHB/Rohypnol/Ketamine) if within *24 hours* of assault and if suspected. *Either* draw and send to Medtox OR give to police for crime lab (gray top). *Do Not Do Both*. Refrigerate.

Urine

- UA (consider evaluating for sperm, trich, and UTI).
- Urine pregnancy. Negative result is needed before prophylaxis for STIs and pregnancy.
- Urine drug investigation test if drug exposure suspected.
- Urine date rape drugs (see above) if date rape suspected within previous *4 days*. Refrigerate (crime lab—10 ml gray top tube, used for urine and/or blood). Collect and send to lab or police for crime lab. *Do Not Do Both*.

STI/Cultures (Not necessary for forensic purposes; consider on an individual basis.)

If discharge is present, then:

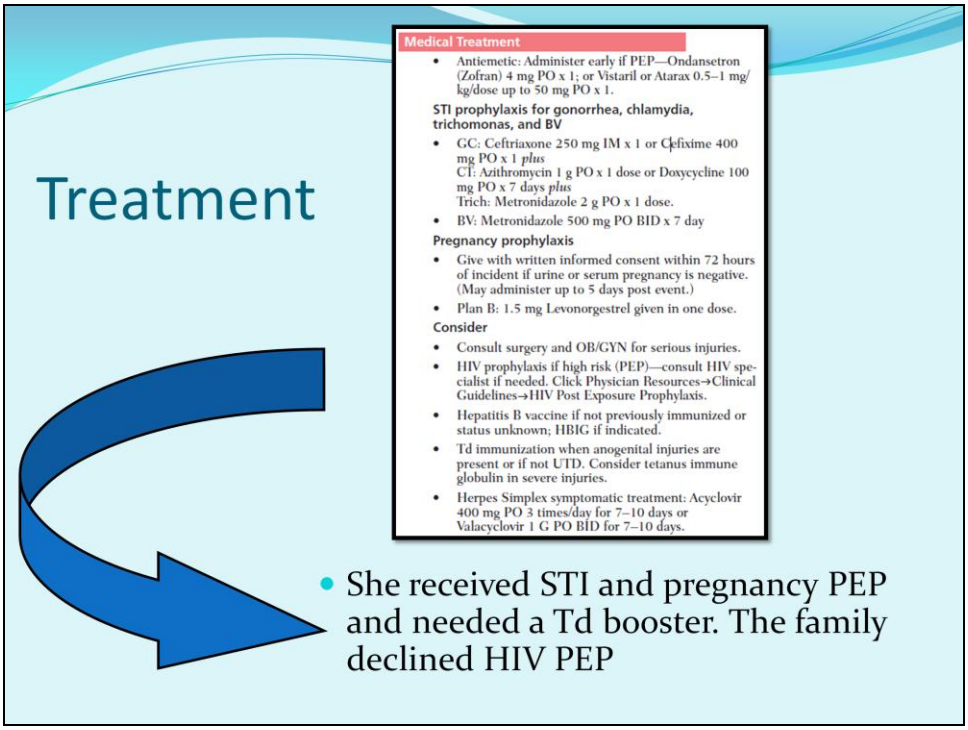
- Cultures (gold standard) and/or NAAT testing (urine/swabs) for gonorrhea and chlamydia.
- Girls—Vaginal wet mount for trichomonads, clue cells, yeast, WBCs, and sperm; whiff; pH.

Optional

- Urine culture (if indicated).
- Trich culture vaginal or urethral specimens.
- Herpes culture (if lesions present). Order HSV shell vial with typing.

- She had laboratory tests drawn

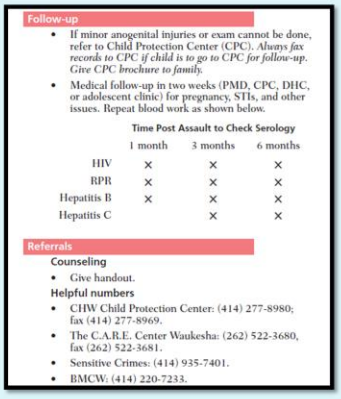
Use the tool to think about any other tests that might be indicated in this particular patient. Since she has dysuria, consider a urine culture which would not usually be part of an acute sexual assault evaluation.



The tool is a useful reminder about what other aspects of treatment might be considered.

Referrals and follow up

- Utilize the Follow-up and Referrals sections to make sure that the family receives appropriate after care.
- Insert your local resources into the tool for easy reference



Follow-up

- If minor anogenital injuries or exam cannot be done, refer to Child Protection Center (CPC). *Always fax records to CPC if child is to go to CPC for follow-up. Give CPC brochure to family.*
- Medical follow-up in two weeks (PMD, CPC, DHC, or adolescent clinic) for pregnancy, STIs, and other issues. Repeat blood work as shown below.

Time Post Assault to Check Serology

	1 month	3 months	6 months
HIV	×	×	×
RPR	×	×	×
Hepatitis B	×	×	×
Hepatitis C		×	×

Referrals

Counseling

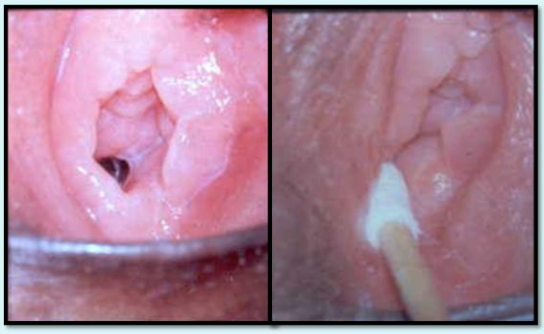
- Give handout.

Helpful numbers

- CHW Child Protection Center: (414) 277-8980; fax (414) 277-8969.
- The C.A.R.E. Center Waukesha: (262) 522-3680, fax (262) 522-3681.
- Sensitive Crimes: (414) 935-7401.
- BMCW: (414) 220-7233.

Once the tool is modified to reflect local resources and practice standards, it can be printed on heavy paper and folded to carry as a useful pocket tool. If a laminated reference is preferred, the tool can be printed as a double-sided PDF and distributed.

Case Continued-2 weeks later



- Acute injuries now resolved
- Hymenal transection at 6:00 that was confirmed using a swab
- Child was in counseling and doing well

Photos - Owned by and provided with permission of Lynn K. Sheets, MD

Transection to the base of the hymen at 6:00 seen at the follow-up exam (child seen at a different site, so the lighting and magnification from the colposcope was different from the initial examination).

Questions?