

**RECOMMENDED MEDICAL GUIDELINE
ACUTE SEXUAL ASSAULT EMERGENCY MEDICAL EVALUATION
FOR THE STATE OF OREGON**

OLDER ADOLESCENT(≥ 15 years)/ADULT

This guideline is recommended for the care of the adolescent (age 15 years and older) and adult when there is a history or concern of sexual abuse or assault. For care of children age 14 years and younger, see the *Recommended Medical Guideline: Acute Sexual Assault Emergency Medical Evaluation – Child/Young Adolescent (< 14 years)*. **However, acute triage assessment should include assessment of the specific aspects of physical and cognitive development of the individual adolescent patient to determine whether the Child or Adult Guideline should be used.** The guideline is not intended to include all the triage issues, medical evaluations, tests and follow-up that may be necessary for appropriate care for an individual patient. For adolescents the timing of the exam, as well as the extent of the exam, depends on the detail and clarity of the history, as well as physical signs and symptoms. Not all the steps outlined in this guideline will be appropriate for every patient. The purpose of this guideline is to provide direction for medical professionals in the care of the older adolescent or adult sexual assault patient. The goal is to ensure that compassionate and sensitive services and care are provided in a non-judgmental manner. The following guideline is based on current Oregon law, Centers for Disease Control and Prevention (CDC), and American College of Emergency Physicians (ACEP) recommendations for the prophylaxis of sexually transmitted diseases and pregnancy, and “best practice” in the care of the sexual assault patient. The physical and psychological well being of the sexual assault patient is given precedence over forensic needs. The guideline represents the basic standards in the medical care of the sexual assault patient.

I. GENERAL INFORMATION

Purpose of Exam

Medical/Forensic

1. Identify and treat injuries
2. Evaluate and treat medical conditions
3. Assess risk of pregnancy and sexually transmitted diseases
4. Provide prophylaxis for sexually transmitted diseases and emergency contraception, when indicated
5. Document history
6. Document medical findings
7. Collect forensic evidence

Social/Psychological

1. Respond to patient’s and family’s immediate emotional needs and concerns
2. Assess patient safety and immediate mental health needs.
3. Explain reporting process, Crime Victims compensation, and resources for advocacy and counseling

Report/Refer

1. Refer for follow-up medical care
2. Refer for advocacy or counseling
3. In the case of minors report to Oregon Department of Human Services (DHS) and/or law enforcement agency (LEA) ASAP
4. Report to LEA in the county where the crime occurred (See section “Mandated Reporting” below)

II. TRIAGE DECISIONS

Acute:
If assault within prior 84 hours

1. Medical/forensic exam is appropriate on an urgent basis in the emergency department
2. For patients less than 15 years old and teenagers with developmental disabilities refer for acute sexual assault exam per community protocol (child abuse assessment center, designated emergency department, etc)
3. Advise patient, if possible:
 - Do not bathe before exam
 - Bring in clothes worn at time of assault and immediately after assault, especially undergarments
 - Bring change of clothing
 - Come to hospital with support person, if possible

Non-Acute:
If assault >84 hours prior
Forensic Exam

Forensic exam is generally not indicated on emergency basis

1. Crime lab generally does not accept evidence collected more than 84 hours after an assault
2. Individual case circumstances may warrant urgent evidence collection beyond 84 hours after assault (i.e., multiple assailants, patient was unconscious for a period of time) or when requested by LEA

Medical Exam

Medical evaluation is indicated for all patients at any time following sexual assault.

1. Patients may be evaluated at the ED or referred to Primary Care Provider (PCP) or clinic for medical care
2. For patients less than 15 years old and teenagers with developmental disabilities refer to your local child abuse center or another facility per community protocol
3. Mandated reporting to DHS and/or LEA for patients under 18 years old
4. Advise or assist patient in making police or DHS report
5. Refer to sexual assault center, advocacy organization or mental health counselor for psychological support

If there is a vague report or concern that abuse occurred, but the last contact was more than 84 hours prior and there are no physical signs or symptoms

1. ED evaluation is not indicated
2. Refer to Primary Care Provider (PCP) or for patients less than 15 years old and teenagers with developmental disabilities refer to your local child abuse center
3. Mandated reporting to DHS and/or LEA for patients under 18 years old

Emergency Department Triage

Medical stabilization always precedes forensic examination

1. The following history or conditions should be evaluated medically prior to the sexual assault exam:
 - History of loss of consciousness
 - Head injury
 - Altered consciousness or mental status
 - Significant facial injury
 - Possible fractures
 - Blunt injury to abdomen or back
 - Active bleeding

Advocacy

2. Psychiatric illness
 - If apparent psychiatric illness complicates assessment of alleged sexual assault, both psychiatric assessment and medical forensic exam generally will be necessary. Proceed according to patient tolerance and needs

The patient should be informed of the right to speak with a Sexual Assault Advocate. If the patient chooses to speak with an advocate, the advocate may be contacted by law enforcement or a medical professional

Mandated Reporting

Life-threatening assault/use of weapons

1. Injury caused by any weapon or incidents involving life-threatening assault must be reported to LEA (per statute) irrespective of reporting the sexual assault

Minors < 18 years

1. Nursing and medical providers are mandated to report to police or DHS when they have a reasonable suspicion of child abuse
2. A report to police and/or DHS is mandatory if victim is under 18 years of age
3. Mandatory reporting applies even when minor has signed for own care
4. Report ASAP
5. The parent or guardian may be encouraged to make a police report with assistance by social services staff

Disabled, Mentally Ill, or Elderly Adults

1. If the patient is age 18 years or older and is disabled, mentally ill, or over the age of 65 years: a report to police and to county Adult Protective Services or State Residential Care Services is mandatory
2. Report ASAP
3. The parent or guardian may be encouraged to make a police report with assistance by social services staff

Adults ≥18 years

If the patient is an adult age 18 years or older and is not disabled, mentally ill or elderly, notification of law enforcement is done only if the patient gives his/her consent

Consent

Informed consent for all procedures, evidence collection and treatments is obtained in all cases

1. Patients age 15 years and older may sign the consent
2. For patients age 14 years and younger, a parent or guardian must sign consent; however, a patient seeking treatment for medical conditions related to reproductive health care may consent to such medical care or treatment at any age and without consent of parent or guardian

III. HISTORY AND INITIAL EVALUATION

Patient Information

Document the following information if it is available and pertinent

1. Routine data: patient name, gender, age, birth date, hospital number, home address, phone number; telephone number for parent or guardian if different
2. Date and time of arrival
3. Who accompanied patient, and their relationship
4. Interpreter name, if used, and language
5. Name of LEA assigned detective
6. Name of DHS caseworker if patient is less than 18 years old or adult protective caseworker if adult is disabled
7. LEA case number, if available

History of Assault**Interview patient and document the following:****Facts about assault**

1. Source of information (patient, police, or other person)
2. Nature of concern
3. Time, place of assault, and jurisdiction/location if known
4. Hours since assault
5. Number of assailants and sexual assailants, identity if known
6. Identity and relationship of alleged offender, if known
7. Record narrative history of assault

Nature of force used

1. Patient had impaired consciousness
2. Known or suspected drug or alcohol ingestion
3. Verbal threats
4. Use of physical force
5. Use of weapon
6. Use of coercion

Physical facts of sexual assault

1. Which orifices assaulted
2. By what (finger, penis, mouth, foreign object)
3. Whether condom was used
4. Whether ejaculation was noted, and where
5. Physical injuries
6. Whether bleeding or pain was reported

Post assault activity of patient

1. Showered or bathed
2. Douched, rinsed mouth, urinated, or defecated
3. Changed clothes, gave clothes to police at scene, or brought clothes worn at time of assault to emergency department/clinic

Risk factors of assailant regarding hepatitis B/C, syphilis, and HIV, if known

1. Known or suspected IV drug use
2. Man who has had sex with men
3. From an endemic country
4. STD history or history of prostitution
5. Blood or mucous membrane exposure

Past Medical History

1. Significant medical problems, surgery, major injuries, chronic diseases, immune problems, developmental, cognitive, mental health and/or physical disabilities
2. Current medications
3. Recent ingestion of other drugs, including over-the-counter drugs, legal and illegal substances, and alcohol
4. Allergies
5. Ob-gyn history
6. Birth control method (IUD, tubal, OCP, etc.)
7. Last menstrual period
8. Last consensual intercourse
9. Patient's history of hepatitis B vaccine or illness

Discussion with Patient

1. Discuss medical and forensic procedures
2. Discuss patient reporting to law enforcement
3. Discuss mandatory DHS and/or LEA report
4. Let patient know that written information and educational literature will be provided

IV. EVIDENCE COLLECTION & STORAGE

Forensic Evidence Collection

1. Standard Sexual Assault Forensic Evidence (SAFE) Kit, provided by Oregon State Police Crime Lab, is used for evidence collection
2. Oregon State Police Sexual Assault Forensic Lab information form

3. The evidence collection exam is done by a registered nurse, nurse practitioner, physician assistant or physician currently licensed in Oregon. The preferred examiner is one who is trained and certified as a Sexual Assault Forensic Examiner

Release of Information

The patient must first be informed of the reasons for the release and written consent obtained before the release of information/documentation is completed

Cost of Evidence Collection

Patients are not charged for the cost of the medical examination, collection of forensic evidence, or STI or EC prescriptions. These costs are paid for by the Department of Justice through its Sexual Assault Victims' Emergency Medical Response Fund. Patients do NOT have to report to police to access these funds; they DO have to report to police in order for the SAFE Kit to be used.

Chain of Custody of Forensic Specimens

One staff member must be responsible for maintaining chain of evidence at all times. That staff member

1. Observes specimens **OR**
2. Designates another staff member to watch specimens **OR**
3. Secures specimens in freezer, refrigerator, cabinet or specific area

Evidence Storage

Temperature

1. Dry or dried evidence may be kept at room temperature
2. Damp or wet evidence or specimens must be kept at cool temperature (refrigerated or frozen) until transfer to avoid molding

Clothing

1. Dry clothing should be placed in paper bags, sealed with tape, signed over seal, and labeled with patient ID label
2. Clothing should be stored in a secure area until transfer to law enforcement
3. Wet clothing must either be dried in a secure area, refrigerated or frozen and transferred ASAP to law enforcement

To process as Forensic Evidence/Evidence Kit

1. Place all evidence in paper bag, kit, or envelope
2. Seal envelope (**do not LICK**), place patient label over seal, sign over seal, and place in Evidence Kit
3. All evidence in the Evidence Kit should be dry
4. Any wet evidence should be refrigerated or frozen and kept with the kit
5. Store entire, sealed Evidence Kit in room temperature secure area, refrigerator, or freezer until transfer to law enforcement
6. Entire Evidence Kit may be refrigerated to keep all items together
7. Blood tubes can be sealed in the Evidence Kit
8. Urine samples should be returned to the box that the urine sample container came in (provided by Crime Lab) or in a heat sealed plastic bag

9. Biological specimens (swabs, slides) should be labeled with site obtained from
 - Swabs from each specific site should be numbered in order obtained for suspect kits (i.e., 1-4)
 - Swabs should be dried in a secure drying box or area before transfer or freezing
 - Biologic specimens should be placed in a secure area until transfer to law enforcement

Injury Documentation

Obtain photographs if visible injuries from abuse are present or request law enforcement to obtain photos. Video or photocolposcopy may be used to document anogenital exam whether injuries are or not present. Alternatives are careful drawings using bodygrams, digital photos, Polaroid photographs, or 35 mm camera with macro lens.

1. Include patient's ID in one photo
2. Take one photo of face and one of entire body, with clothes on, prior to exam
3. Include a ruler or coin in some photos of injuries to document size of lesions
4. For 35 mm: use new film role for each patient, place patient label on metal film canister
5. For Polaroids: place patient label on each photo and secure in patient chart
6. Document type of photos, parts of body in photos, and name of photographer in medical chart
7. Place labeled 35 mm film canister in envelope and send for processing to hospital/clinic-associated photography lab
8. All photos should have patient label on back and examiners initials
9. Place in patient chart according to hospital protocol.
10. Careful documentation with drawings is advised even when photos are taken
11. Order double copies of photos if LEA did not obtain own photos

Evidence Collection

General

Wear powder-free gloves and change gloves frequently during all phases of evidence collection and processing

Fingernail Debris/Scraping

Collect if patient reports scratching assailant or examiner believes nail debris may be related to assault. Obtain when visible debris or blood under nails, nails broken during assault and/or history suggests patient scratched offender

1. Place small paper sheet labeled "Left hand" or "Right hand" on flat surface
2. Using disposable plastic scraper or clean, disposable blunt metal scissors, or sterile clipper/scissors, scrape under all five fingernails of left hand, allowing any debris to fall onto paper
3. Alternatively, with patient's permission, cut fingernails
4. Patient may be able to do this with direct supervision
5. Bindle paper (using a square or rectangular piece of paper, fold all edges inward so that there are no open edges) to retain debris and scraper
6. Fold scraper in paper, place each paper in a separate labeled envelope
7. Seal envelope (**do not LICK**), place patient label over seal, sign over seal and store securely in the Evidence Kit

Skin and Hair Debris	<p>Collect when foreign material is visible on patient's skin or hair and patient reports, or examiner believes, debris is related to assault. Collect grass, fibers, paint flecks, etc., which may adhere to patient's skin. Omit this step if patient bathed or if no debris visible</p> <ol style="list-style-type: none"> 1. Place small paper sheet on flat surface 2. Collect any foreign debris (dirt, leaves, fiber, hair, etc.), place in center of paper 3. Bindle paper (using a square or rectangular piece of paper, fold all edges inward so that there are no open edges) to retain debris 4. Place each folded sheet in an envelope and label with site 5. Seal envelope (do not LICK), place patient label over seal, sign over seal and store securely in Evidence Kit
Trace Evidence Collection	<p>To collect foreign material which may fall when patient undresses. Omit if patient has bathed or changed clothes since assault</p> <ol style="list-style-type: none"> 1. Place bed sheet or large paper sheet on floor. This is to prevent floor debris from adhering to evidence collection paper 2. Unfold and place evidence collection paper sheet over the bottom sheet 3. Instruct patient to stand in the center of paper and remove clothing 4. Bindle paper (using a square or rectangular piece of paper, fold all edges inward so that there are no open edges) where patient stood, retaining any foreign material, and place in paper envelope and process as forensic evidence: seal in envelope, label, sign over seal and place in the Evidence Kit
Clothing Collection	<p>If assault occurred out of doors, or clothing was stained or damaged during assault, collection is particularly important. Do not collect the clothes if the patient is wearing clothing other than what was worn during or immediately after the assault. Wet clothing should be dried in a secure room or area, or transferred to law enforcement ASAP. Do not cut through any existing holes, rips, or stains. Do not shake out victim's clothing or trace evidence may be lost</p> <ol style="list-style-type: none"> 1. Place each item of clothing in a separate paper bag 2. Place patient label on each bag. Tape each bag closed, and sign over tape 3. Maintain chain of evidence for clothing bags. Place in secured area when not directly observed
Underpants	<p>Collect patient's underpants routinely, even if changed after assault</p> <ol style="list-style-type: none"> 1. Pooled secretions may leak onto underwear 2. Package patient's underpants in a small paper bag. Seal, label, sign over label, and store securely in a clean paper bag
Other Items	<p>Collect items which may contain forensic evidence, such as tampon or pad, and condom. These should be collected on a case-by-case basis</p> <ol style="list-style-type: none"> 1. Place in plastic bag and freeze or refrigerate until pick-up by LEA. 2. If freezer/refrigerator is not available, air dry the item if possible. If unable to air dry, package the item in a non-air tight container, such as a urine cup with holes in the lid to allow the item to dry. Contact LEA for transport ASAP. 3. Place patient label over seal, sign over seal, and store with Evidence Kit or in separate paper bag

Processing Forensic Swabs (For recovery of DNA)

Obtain forensic swabs for recovery of DNA (saliva, seminal fluid & perspiration)

1. Use sterile cotton swabs
2. To obtain swabs from dry areas (e.g., skin, fingertips, rectum, and any areas that fluoresce) lightly moisten swabs with tap water (soaking in water will prolong drying time and increase likelihood of specimen molding)
3. To obtain swabs from wet areas (e.g., mouth, vagina) use dry sterile cotton swabs

As each swab is obtained

1. Affix label on the shaft
2. Write on each label the site of specimen (e.g., "skin," or "oral," "vaginal," "anal").
3. At conclusion of patient exam, place swabs in drying rack or drying box in secure area
4. Allow swabs to dry

When swabs are dry

1. Place all swabs from same site in one envelope (i.e., only one site per envelope)
2. Label envelope with specimen site (e.g., "oral," "vaginal," "skin")
3. Affix patient label to envelope
4. Seal envelope with tape or patient label. **Do not LICK** envelope to seal
5. Place patient label over seal, sign over seal, and store securely in Evidence Kit

Processing Forensic Slides (when sperm is suspected to be present)

Prepare forensic slides from swabs collected from areas where seminal fluid is suspected to be present

1. Before drying swabs, use first obtained swab, rub cotton tip in dime-size area on center of slide. Do **NOT** throw away swab. Process this swab with other swabs from same site
2. In pencil, label end of slide with location swab was obtained from
3. Place slide in open cardboard sleeve and air dry for 5 minutes
4. Close cardboard sleeve, seal with patient label, sign over seal and store securely in Evidence Kit

Processing Evidence Collection Kit

1. Once all evidence has been placed inside the kit
 - Complete the Forensic Laboratory Information Form found inside the kit
 - Complete the information requested on the front of the kit
 - Place a patient label over the envelope, seal and initial
 - Give the kit to the LEA representative and have him/her sign the Forensic Laboratory Information Form. A copy of this form should be filed in the patient's chart
2. If no LEA representative is available, store the kit in a secure area, then contact LEA immediately and give them the location of the completed kit so LEA can pick it up ASAP

Drying Box

1. Clean drying box with antimicrobial cleaning solution per institution protocol

V. INITIAL LAB TESTS

Pregnancy Test

Obtain urine or serum pregnancy test on all patients at risk of getting pregnant (post menarchal patients, and all premenarchal girls Tanner Stage 3 and above or age 12 years or older)

Toxicology Tests

Obtain toxicology and/or alcohol level when:

1. Patient appears impaired, intoxicated, or has altered mental status
2. Patient reports blackout, memory lapse, or partial or total amnesia for event
3. Patient or other is concerned that he or she may have been drugged
4. Separate consents for toxicology specimens need not be obtained, but patient should be informed that specimens are obtained

Hospital toxicology

1. If toxicology and/or alcohol results are needed for patient care, stat hospital toxicology tests must be done

Crime lab toxicology

1. Drug and alcohol testing may be done for legal purposes; legal specimens follow a chain of custody and generally are given to LEA (not processed through hospital lab).
2. In some circumstances examiner may order tests to be run at "any detectible level," rather than the standard cut off. Talk with the lab toxicologist to determine how to order
3. GHB and Rohypnol must be specifically requested.
4. When it is deemed necessary to collect samples for toxicology purposes, collect *blood* for alcohol testing and *urine* for drug testing. **Urine must be obtained as soon as possible.**

VI. MEDICAL EXAMINATION

General Information

1. All patients should receive a complete head-to-toe physical examination
2. It is the patient's right to consent or refuse any aspect of the exam and evidence collection
3. The patient may have a support person (relative, friend, or advocate) present during the exam
4. If suspected or known oral sodomy, it is preferable that the patient does not eat or drink before the exam, but the patient's comfort should not be compromised to achieve this
 - Oral swabs, for example, should be obtained immediately if patient is thirsty or wishes to rinse mouth
5. Use powder free gloves and change gloves frequently during exam and evidence collection
6. General
 - Document developmental level, emotional status, mental status and general appearance
 - Document objective observations: "patient avoids eye contact and is teary-eyed" is preferable to "patient is sad"
 - Vital signs, height and weight

Exam Procedures

1. Because a patient may not initially report all aspects of the assault, collect evidence routinely from the mouth and vagina. Collect swabs from the rectum if there is any possibility that evidence may be found there.
2. If the patient has bathed or showered, specific steps of evidence collection should be omitted. These steps are indicated in the following sections
3. The following sections outline the steps for the medical exam and the collection of evidence. The order of these steps may vary by examiner preference or patient need

Skin Exam

Bruises, petechiae, abrasions, lacerations, and bite marks, and suction ecchymoses, tenderness

1. Describe traumatic lesions and mark on traumagram
2. Ask patient how each injury occurred and document patient's statements
3. Confirm that photos have been taken and a drawing completed of acute traumatic skin lesions
4. Using Wood's lamp or Mini Bluemaxx™ with room lights dimmed: scan patient's skin surface, including breasts, abdomen, perineum, hair, face, buttocks, and thighs
 - Semen may fluoresce
 - Document presence/absence and location of fluorescence

Forensic Swabs

Collect when assault occurred within last 84 hours and the patient has not bathed:

1. Patient reports alleged assailant's blood, semen, or saliva may be deposited on skin **or**
2. Assailant's blood or dried secretions are visible **or**
3. Assailant's bite marks or suction ecchymoses are visible **or**
4. Wood's lamp or Mini Bluemaxx™ scan is positive

Swab and Slide Technique

1. Use 4 cotton swabs
2. Use 2 swabs at a time if possible to save time
3. Lightly moisten swabs with tap water if secretions are dried
4. Swab areas of possible dried secretions
5. Label swabs with site where collected, number 1-4 in order obtained
6. **Slides are made only when the presence of semen is suspected**
Using swab #1, rub cotton tip on dime-size area on center of the slide. Retain this swab for labeling and processing with the other 3 swabs from this site.
7. Process slide as forensic evidence
8. Process swabs as forensic evidence

Oral Exam

Document

Lacerations, abrasions, petechiae, and bruises. Check mucosa, palate, upper/lower frenula, and tongue

Forensic Swabs

Collect when

1. Abuse/assault occurred within prior 12 hours **or**
2. Visible oral injury **or**
3. History of oral/genital contact in prior 12 hours

Reference Swabs

Collect reference oral standard swabs to establish patient DNA (draw blood for reference DNA if history of oral sodomy)

1. Use 4 swabs
2. Vigorously swab inside of cheek of the mouth
3. Process as forensic swab

Pubic Hair Collection

**Pubic Hair Combing
For Male and
Female**

To collect foreign hairs and debris. Omit this step if patient bathed or showered after assault. Omit if pubic hair is not present or has been shaved

1. Either patient or examiner may do actual combing (if patient, examiner must observe)
2. Patient should be sitting or lying in dorsal lithotomy position
3. Place paper sheet under victim's buttocks
4. Using disposable comb, comb pubic hair in downward strokes so that any loose hairs and/or debris will fall onto paper
5. Bindle paper to retain both comb and any evidence present
6. Place in envelope, place label on envelope with contents identified
7. Process as forensic evidence (hairs obtained from the pubic combing will not be processed unless a reference sample is collected from the victim)

**Pubic Hair Plucking
and Cutting for
Male and Female**

DO NOT AUTOMATICALLY PLUCK PUBIC HAIRS: Pluck pubic hairs when one or more of the following conditions apply:

- Stranger or unknown assailant or multiple assailants
- Pubic hair is collected in the pubic combing
- Assailant is an acquaintance that has not previously been in the environment where the assault(s) occurred.

Never cut pubic hair, only pluck. ASK THE VICTIM IF SHE WANTS TO PLUCK HER OWN. Pluck 10 hairs from all around the pubic area.

Genital Exam – Female

Document

Genital lacerations, abrasions, bruises, petechiae, erythema, inflammation, bleeding, edema, and discharge; Tanner Stage

Forensic Swabs

Collect when

1. Assault occurred within prior 84 hours **and**
2. History of penile-genital or oral-genital contact **or**
3. Report of contact to genitalia, perineum, or anus by any part of assailant's body **or**
4. Ejaculation occurred near anogenital area **or**
5. Visible acute genital or anal injury **or**
6. Wood's lamp or Mini Bluemaxx™ scan is positive

1. Use vaginal speculum to visualize vagina and cervix, and note lacerations, abrasions, petechiae, and bruising
2. Do not use lubricant (e.g., surgilube) for speculum. Rinse speculum in warm water for patient's comfort

Internal Genital Area Swabs

For young adolescents who have not had a prior pelvic exam, or any patient who cannot tolerate a speculum exam, forensic swabs may be collected by directly inserting swabs 2-3 inches into the vagina

1. Sites to consider swabbing
 - Inner labial folds
 - Posterior fossa
 - Vagina (particularly posterior vaginal pool)
 - Endocervix
2. Use 4 swabs total for each site
3. Use 1 or 2 swabs at a time. Do not moisten swabs for areas that are moist

Slides are made only when the presence of semen is suspected

4. Using swab #1, rub cotton tip on dime-size area on center of the slide. Retain this swab for labeling and processing as other 3 swabs from the same genital area
5. Process as forensic slide evidence
6. Process as forensic swab

External Genital Area Swabs**Collect routinely when report of contact to genitalia, perineum, or anus by any part of assailant's body.**

1. Sites to consider swabbing
 - Inner thighs
 - Inguinal folds
 - Mons pubis
 - External labia majora
 - Perineal body
2. Use 4 cotton swabs
3. Use 2 swabs at a time
4. Lightly moisten swabs with water if site is dry
5. Swab one specific area
6. Repeat with 2 remaining swabs

Slides are made only when the presence of semen is suspected

7. Using swab #1, rub cotton tip on dime-size area on center of the slide. Retain this swab for labeling and processing as other 3 swabs from the same genital area
8. Process as forensic slide evidence
9. Process as forensic swab

Intravaginal/Cervical Swabs**Collect routinely when report of contact to genitalia, perineum, or anus by any part of assailant's body. For young adolescents who have not had a prior pelvic exam, or any patient who cannot tolerate a speculum exam, forensic swabs may be collected by directly inserting swabs 2-3 inches into the vagina**

1. Use vaginal speculum to visualize vagina and cervix, and note lacerations, abrasions, petechiae, and bruising
2. Do not use lubricant (e.g., surgilube) for speculum. Rinse speculum in warm water for patient's comfort
3. Sites to consider swabbing
 - Inner labial folds
 - Posterior fossa
 - Vagina (particularly posterior vaginal pool)
 - Endocervix
4. Use 4 swabs total for each site
5. Use 1 or 2 swabs at a time. Do not moisten swabs for areas that are moist

Slides are made only when the presence of semen is suspected

6. Using swab #1, rub cotton tip on dime-size area on center of the slide. Retain this swab for labeling and processing as other 3 swabs from the same genital area
7. Process as forensic slide evidence
8. Process as forensic swab

Genital Exam – Male**Document**

Penile, scrotal or perineal abrasions, bruises, lacerations, petechiae, bleeding, edema, discharge, erythema, and inflammation, tenderness, Tanner Stage

<p>Forensic Swabs</p>	<p>Collect if report of assailant saliva or secretions on victim's genital/perineal area.</p> <ol style="list-style-type: none"> 1. Retract foreskin to examine glans penis 2. Areas to consider swabbing <ul style="list-style-type: none"> • Mons pubis • Inner thighs • Inguinal folds • External surface of glans/penis • Under foreskin (collect swabs even if patient has bathed or showered) • Scrotum • Perineal body 3. Swab surface of specific area with 2 swabs lightly moistened with tap water 4. Repeat with 2 moistened swabs 5. For each specific site, dry swabs, label site and label order of swabs obtained (i.e., 1-4) <p>Slides are made only when the presence of semen is suspected</p> <ol style="list-style-type: none"> 6. Using swab #1, rub cotton tip on dime-size area on center of the slide. Retain this swab for labeling and processing as other 3 swabs from the same genital area 7. Process as forensic slide evidence 8. Process as forensic swab
<p><u>Perianal and Anal Exam- Male and Female</u></p> <p>Document</p> <p>Exam Technique</p>	<p>Perianal bruising, petechiae, edema, discharge, bleeding, tenderness, abrasions, lacerations, erythema, inflammation, and visible anal laxity</p> <ol style="list-style-type: none"> 1. Use good light source 2. Use magnification with otoscope, visor, or colposcope 3. Separate anal folds to visualize injuries 4. Digital exam is not indicated, except if concern for foreign body retention 5. Anoscopy is indicated only if there is active rectal bleeding or rectal pain 6. Lubricant should be used for anoscopy. To avoid contamination by lubricant, perform anoscopy only <u>AFTER FORENSIC SWAB COLLECTION</u> 7. Apply Toluidine blue to identify abrasions on skin surface only <u>AFTER FORENSIC SWAB COLLECTION</u>
<p>Forensic Swabs</p>	<p>Collect when</p> <ol style="list-style-type: none"> 1. Assault occurred within prior 84 hours and 2. History of penile-genital or penile-anal contact or 3. Report of contact to genitalia, perineum, or anus with any parts of assailant's body or 4. Visible acute anal trauma or 5. Wood's lamp or Mini Bluemaxx™ scan is positive

External Anal/Perianal Swabs

1. Sites to consider swabbing
 - Perianal area (external to anal sphincter)
 - Anus
 - Gluteal cleft
2. Lightly moisten swabs with tap water before using
3. First 2 swabs: using 2 swabs at a time, swab external anal rugal area. Repeat with second 2 swabs

Slides are made only when the presence of semen is suspected

4. Using swab #1, rub cotton tip on dime-size area on center of the slide. Retain this swab for labeling and processing as other 3 swabs from the same area
5. Process as forensic slide evidence
6. Process as forensic swab

Internal Anorectal Swabs

Collect rectal swabs routinely when patient reports contact to anus by any part of assailant's body

1. Use 4 cotton swabs total
2. Lightly moisten swabs with tap water before using
3. Swab perianal folds using 2 moistened swabs
4. Using swab #1, rub cotton tip on dime-size area on center of the slide. Retain this swab for labeling and processing with other swab from same area
5. Clean the perianal tissue with water
6. Slowly insert 1 swab past anal sphincter (approximately 2 cm) Slowly withdraw swab. Repeat with remaining swab
7. Using swab #1, rub cotton tip on dime-size area on center of the slide. Retain this swab for labeling and processing with other swab from the same area
8. Process as forensic slide evidence
9. Process as forensic swab

VII. DIAGNOSTIC TESTS FOR MEDICAL TREATMENT

The following tests and procedures are not recommended for forensic purposes but may be done for patient care at the patient's expense (Crime Victims' Compensation may be available)

Pregnancy Test

Obtain urine or serum pregnancy test on all patients at risk of getting pregnant (post menarchal patients, and all premenarchal girls Tanner Stage 3 and above or age 12 years or older) prior to administration of emergency contraception

Toxicology Tests

(Refer to Section V "Initial Lab Tests")

Vaginal Wet Mount

1. Not recommended to examine for sperm, due to lack of reproducibility and standardization
2. May be used to assess vaginitis if signs or symptoms are present

STD Tests for Gonorrhea and Chlamydia

1. STD testing, if done at time of acute assault, should be repeated at follow-up visit
2. Specimens for STD testing go to hospital/clinic lab NOT to crime lab
3. Inform patient that these tests are related to health issues and are not exclusively for forensic purposes
4. Positive tests may indicate pre-existing infection. Highly sensitive tests such as Molecular Amplified Detection (MAD) may also indicate infection in assailant
5. For vaginal or penile infection
 - Urine MAD test or vaginal or penile culture for gonorrhea and chlamydia
 - Positive MAD test must be confirmed by culture
6. For anal infection
 - Culture for gonorrhea and chlamydia
 - MAD test cannot be done
7. For pharyngeal infection
 - Culture for gonorrhea
 - Do not culture for chlamydia

STD Tests for Syphilis and Syphilis Serology

1. Syphilis baseline test may be offered with knowledge of community epidemiology
2. Syphilis serology is best done 3 months after last contact

HIV Testing

1. Baseline HIV testing is generally NOT recommended in the emergency department
2. Baseline HIV testing may be performed up to 2 weeks after assault, and may be performed in follow-up visit or preferably by the primary care provider
 - If patient wishes HIV serology testing in the emergency department, pre-test counseling must be done and post-test counseling arranged
 - Patient must exhibit understanding that testing does not reflect acquisition of HIV from the assault, but related to possible exposure 2 months or more prior
3. If testing is done, arrangements must be made for follow-up visit to discuss results

Hepatitis Serology

1. Indicated if patient is unsure of hepatitis B immune status
2. Hepatitis B/C serology is best done 3 months after last contact

VIII. TREATMENT

Pregnancy Prevention

Every patient who is post menarchal will be offered prophylactic treatment for pregnancy prevention. If the patient declines pregnancy prophylaxis, a refusal of consent must be obtained

Offer emergency pregnancy prophylaxis when:

1. Patient is at (2% to 5%) risk for pregnancy and
 - patient is not using highly reliable method of contraception such as oral contraceptives (no pills missed in cycle), Depo provera or IUD and
 - patient feels any pregnancy conceived in the last five days would be undesirable to continue and
 - pregnancy test is negative
2. Patient must sign consent for emergency prophylaxis
3. Since the effectiveness of emergency prophylaxis is time dependent, if possible the patient should obtain medications prior to discharge or as soon as possible

Evidence suggests that emergency contraception MAY be effective as far as 120 hours after unprotected sex. (Rodrigues, *et al.*, Am J Obstet Gynecol 2001; 184:531) Medications for patients who have a negative pregnancy test and are at risk for conception may be given as follows:

“Plan B” (progestin only medication)
 SIG: 100 mg tab (0.75 mg levonorgestrel)
 Take 2 tabs immediately (Von Hertzen, et al., The Journal of Family Practice, April 2003, Vol. 52, No. 4)
 Quantity: 2
 “Plan B” is more effective and with fewer side effects than combined estrogen/progestin oral contraceptive; anti-emetics are not generally needed

Alternative Regimens:

Combination estrogen/progestin medications
 1 dose to be taken immediately and again in 12 hours

Trade Name	Pills Per Dose
Preven Kit	2 blue pills
Ovral	2 white pills
Alesse	5 pink pills
Nordette	4 light-orange pills
Levlen	4 light-orange pills
Lo/Ovral	4 white pills
Triphasil	4 yellow pills
Tri-Levlen	4 yellow pills

Anti-emetics

An anti-emetic medication should be prescribed when combination estrogen/progestin OCs are taken or as needed
 Metoclopramide: 10 mg po q 6 hours prn
 Meclizine 25-50 mg po q 24 hours prn
 Diphenhydramine 25-50 mg po q 4-6 hrs prn
 Trimethobenzamide 200mg pr/300mg po q 6-8 hrs prn
 Promethazine 12.5-25 mg po/pr q 4-6 hrs prn
 Dramamine 25-100 mg po q 4-6 hrs prn; NTE 400mg/24hr
 Doses of anti-emetics may be altered based on the patient’s age, weight or concurrent medications

STD Prophylaxis

Every patient will be offered prophylactic treatment for sexually transmitted diseases per current CDC guidelines.

The following recommended antimicrobial regimen for treatment of chlamydia, gonorrhea, trichomonas, and BV may be administered to **pregnant** and **non-pregnant** adolescent and adult patients of acute sexual assault (MMWR, May 10, 2002 and <http://www.cdc.gov/STD/treatment>):

Ceftriaxone 125 mg IM in a single dose (GC)
 PLUS
Metronidazole 2 g orally in a single dose (trich/BV)
 PLUS
Azithromycin 1 g orally in a single dose (chlamydia)

Alternative Medication Regimens

1. Chlamydia

Erythromycin base 500 mg PO QID x 7 days

OR

Erythromycin ethylsuccinate 800 mg PO QID x 7 days

OR

In non-pregnant patients:

Doxycycline 100 mg PO BID x 7 days

OR

Ofloxacin 300 mg PO BID x 7 days

OR

Levofloxacin 500 mg PO x 7 days

2. Gonorrhea

In non-pregnant patients:

Ciprofloxacin 500 mg PO in a single dose

OR

Ofloxacin 400 mg PO in a single dose

OR

Levofloxacin 250 mg PO in a single dose

Hepatitis B Vaccine

Offer when

1. Patient has not been previously fully immunized for hepatitis B **and**
2. Patient has negative history for hepatitis B **and**
3. Secretion-mucosal contact occurred during assault **and**
4. Patient signs consent for immunization
5. Inform patient that repeat vaccine doses are necessary at one month and six months after initial vaccine
6. If the patient is unsure of their immunization status or has been partially immunized, a Hepatitis B titer may be drawn. At the time of discharge, provide the patient with instructions for appropriate follow up of titer results and completion of vaccine series

Tetanus Prophylaxis

Offer when

1. Skin wounds occurred during assault **and**
2. Patient not up-to-date for tetanus immunization (no immunization in past five years)
3. Patient signs consent for immunization

HIV Prophylaxis

Every patient will be offered prophylactic treatment for sexually transmitted diseases, with the exception of HIV. In the case of HIV, the patient will be offered information regarding HIV and appropriate medical follow up for HIV. Prophylactic treatment for HIV may be started in the emergency department if the supervising physician deems it appropriate and the emergency department has prophylactic HIV protocols in place

Generally prophylaxis not recommended, except in cases of high risk assault:

- Assailant gay or bisexual male, IV drug user, prostitution history or from endemic area
- Assailant known to have HIV
- Multiple assailants
- Blood or mucous membrane exposure

IX. DISCHARGE AND FOLLOW UP MEDICAL VISIT

Discharge

1. Discuss safety issues/plan
2. Appropriate medical follow up will be identified for the patient with respect to the evaluation of possible sexually transmitted diseases, pregnancy and any physical injuries sustained during the assault
3. Explain follow-up for test results
4. Offer patient education materials
5. Confirm plans for medical and counseling follow-up
6. Give phone number for sexual assault victim advocate and other support services
7. Follow up counseling information will be provided to the patient by the sexual assault advocate or the forensic examiner
8. Give written discharge instructions for all treatment and follow up
9. Information on area resources concerning: medical follow up, crisis intervention phone numbers, sexual assault crisis centers, shelters, DHS Child Welfare, Crime Victims Compensation Program, law enforcement and the district attorney’s office will be given to the patient at the time of discharge
10. Per community protocol, refer minor patients to local child abuse intervention center for medical and forensic follow-up

Follow Up

Recommended within two weeks of the initial exam

Medical Visit

Review with patient or guardian

1. Emergency department/clinic record
2. Lab results
3. Current physical symptoms
4. Emotional reactions (sleep disorders, anxiety, depressive symptoms, flashbacks, other)
5. Concerns for safety
6. Concerns regarding STDs and HIV
7. Assess social support (family, friends)
8. Additional history or any new information regarding the assault
9. If patient is a minor or a disabled, mentally ill, or elderly adult, report any new allegations to LEA and appropriate protective services agency

Physical Exam

Depending on history and symptoms

1. Evaluate for resolution and healing of injury
2. Evaluate current symptoms

Laboratory Tests

Depending on risk and patient concerns

1. Obtain urine pregnancy test. Let patient know that this is only a screening test and should be repeated if patient does not have a regular menstrual period
2. Urine LCR or culture for gonorrhea and chlamydia if single dose prophylaxis was not given in emergency room
3. HIV: pre-test and post-test counseling required after exposure
 - Baseline
 - Three months
 - Six months
4. Hepatitis B/C serology--three months after exposure
5. Syphilis serology--three months after exposure

Treatment	<ol style="list-style-type: none">1. Prophylaxis with Hepatitis B vaccine may be initiated up to 14 days post assault; indicated if there has been secretion-to-mucosal contact and if patient has not been fully immunized; counsel regarding completion of series2. Assess and treat anogenital complaints and any other medical conditions as needed
Referral	Refer for further medical follow-up, mental health and social services