Suspected Sexual Abuse

Nina Livingston, MD

Special thanks to: Sarah Dean, DNP, APRN

What is a Clinical Pathway?

An evidence-based guideline that decreases unnecessary variation and helps promote safe, effective, and consistent patient care.

Objectives of Pathway

- Create standardization of clinical care for suspected sex assault/abuse
- Direct appropriate history gathering from the child and family
- Properly identify who should have forensic evidence collections kits performed and how to execute evidence collection appropriately
- Help providers to think about the medical, forensic, safety and mental health components required when caring for a child of suspected sex assault or abuse
- Ensure appropriate Department of Children and Families (DCF) reporting
- Link the child to appropriate medical follow up
- Serve as a guide for medical providers who are determining if a child needs to be sent to the children's emergency department

Why is the Pathway Necessary?

- Create standardization of clinical care for suspected sex abuse/assault
- Help providers to think about the medical, forensic, safety, and mental health components required when caring for a child of suspected sex assault or abuse
- Serve as a guide for outpatient medical providers who are determining if a child needs to be sent to the CT Children's emergency department or not, thereby decreasing unnecessary ED visits or transfers from outside hospitals
- Direct appropriate history gathering from the child and family
- Properly identify who should have forensic evidence collection kits performed and how to execute evidence collection appropriately
- Ensure proper STI testing and treatment is provided in the correct circumstances, based on CDC guidelines
- Ensure appropriate Department of Children and Families (DCF) reporting
- Link the child to appropriate medical follow up

Background

This pathway was developed to guide decision making and assure that **medical, forensic, and safety concerns are simultaneously addressed** when a child presents with a concern of sexual abuse or assault.

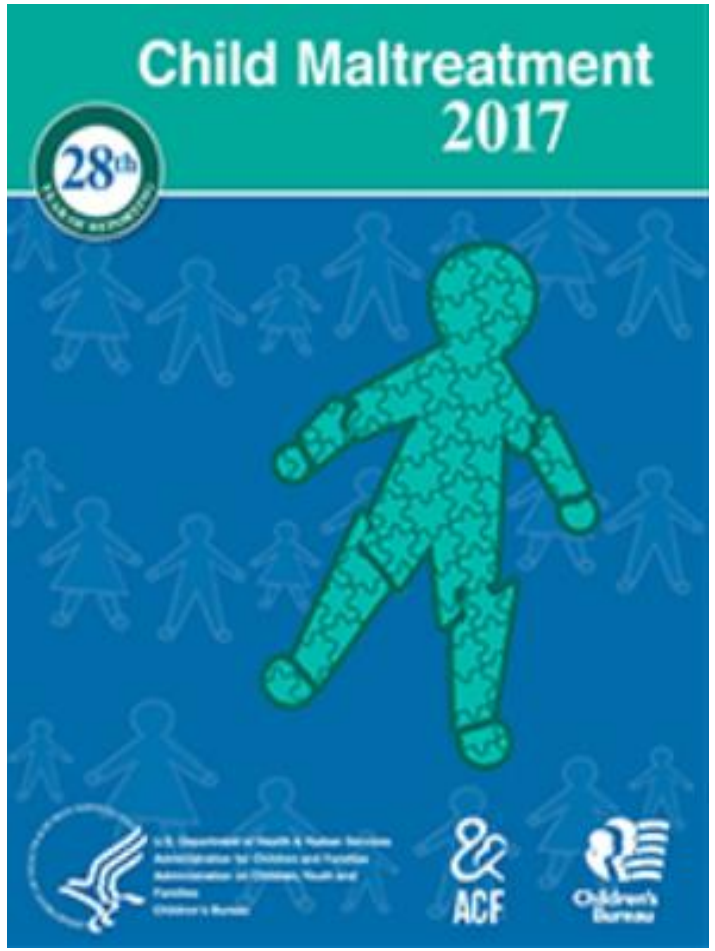
The medical care needed depends on the:

- Age of the child
- Type of sexual contact
- How recently the sexual contact occurred
- The age of the alleged perpetrator
- Symptoms
- Medical findings on exam

In addition to medical care the following must be addressed:

- Need for forensic evidence collection
- Alerting the proper authorities
- Determination of safe discharge planning
- Mental health needs of the child and family

Background



674,000 substantiated cases of child maltreatment in the U.S. in 2017

- 74.9% - neglect
- 18.3% - physical abuse
- 8.6% - sexual abuse

Some forms occur in combination

In Connecticut

- According to the Child Maltreatment report of 2017, there were 8,442 victims of maltreatment
  - 401 involved sexual abuse/assault

- Since 2008, there have been over 1,000 children between the ages of 2 and 18, referred for CSEC (Commercial Sexual Exploitation of Children)
  - Since 2016, there have been over 200 cases/year of CSEC

Sexual Abuse vs Sexual Assault

Sexual abuse of a child is ongoing, often non-violent, and is often performed by a known adult caregiver or older child

Sexual Assault is a one-time event, is often violent and the perpetrator is often a stranger or same-aged peer

Finkelhor 2014 Journal of Adolescent Health

When to Consider Sexual Abuse/Assault

- A child makes a disclosure of sex assault or abuse
- When another person witnesses sex assault or abuse
- When a child has symptoms of, or a diagnosis of, a sexually transmitted disease or is pregnant
- When there are signs of anogenital trauma on exam
- When a caregiver expresses concerns of sex assault or abuse

The Most Common Finding in a Sexual Abuse Evaluation is…

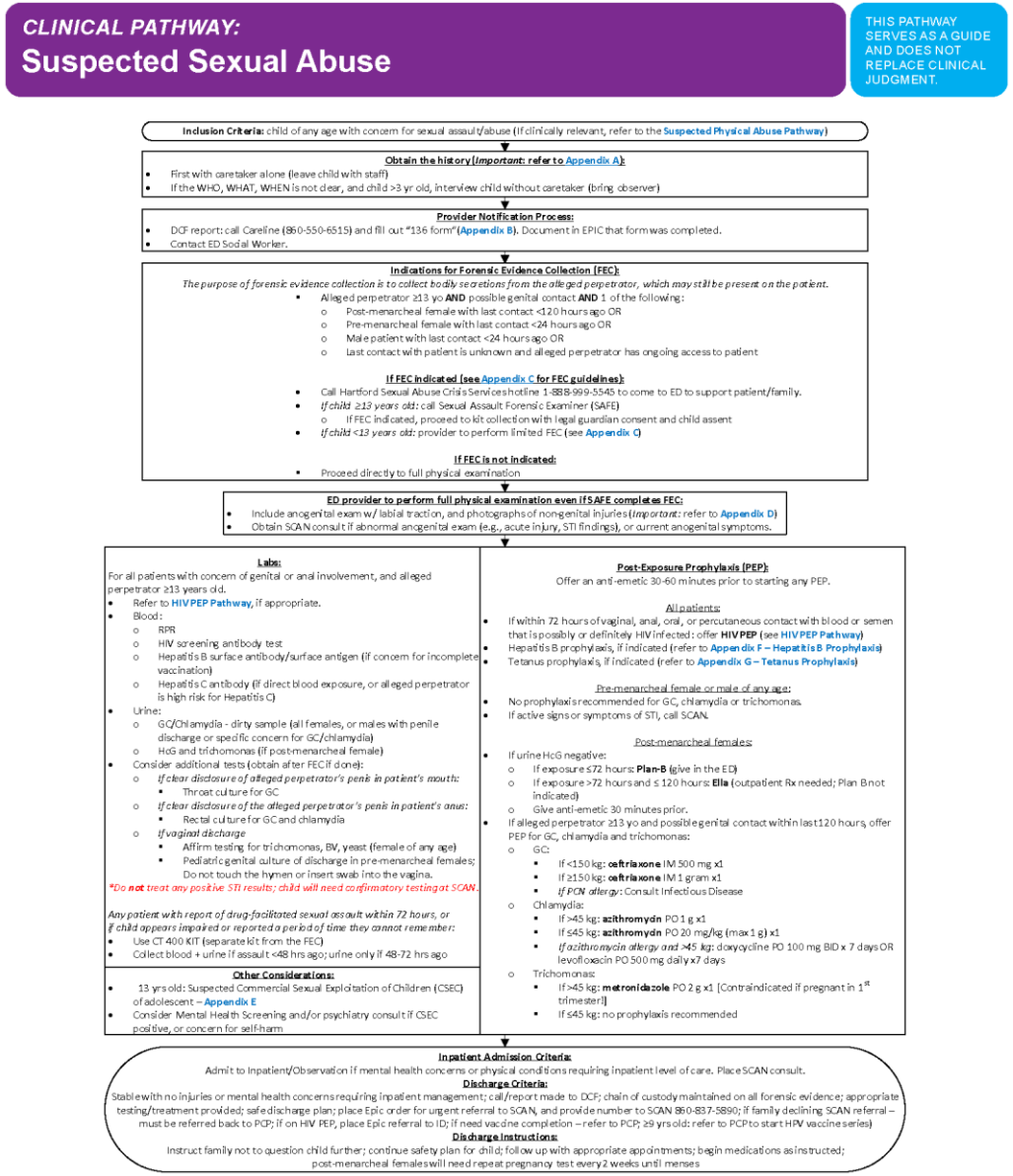
A NORMAL EXAM

Why Are Sexual Abuse Exams Usually Normal?

- Genital and anal structures heal rapidly and completely
- Genital and anal structures are elastic, allowing for penetration without injury
- Many sexually abusive acts do not involve injury
- Delayed disclosure results in loss of physical exam findings

This is the Suspected Sex Abuse Clinical Pathway.

We will be reviewing each component in the following slides.



Inclusion Criteria: child of any age with concern for sexual assault/abuse (If clinically relevant, refer to the **Suspected Physical Abuse Pathway**)

Suspected Sexual Abuse

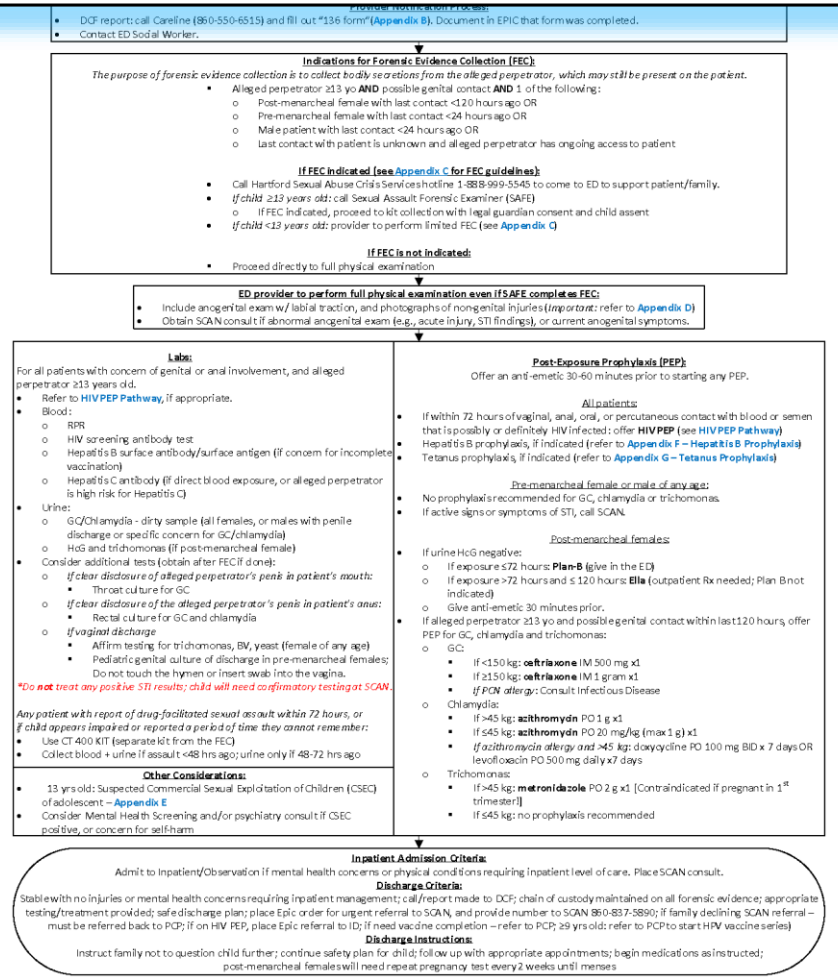
REPLACE CLINICAL JUDGMENT

Obtain the history (*Important*: refer to **Appendix A**):

- First with caretaker alone (leave child with staff)
- If the WHO, WHAT, WHEN is not clear, and child >3 yr old, interview child without caretaker (bring observer)

Any child with suspicion of sexual assault or sexual abuse should be included.

If there is any suspicion for physical abuse, also refer to the care on the Suspected Physical Abuse Clinical Pathway.



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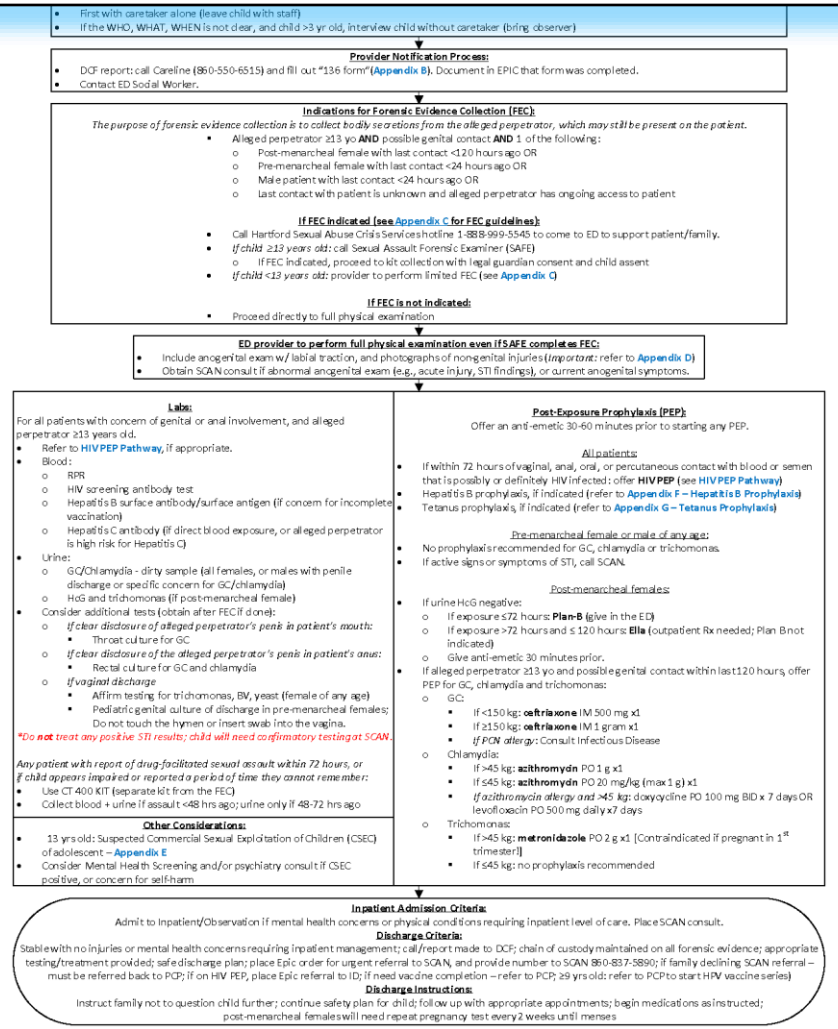
CLINICAL PATHWAY: … SERVES AS A GUIDE …

Obtain the history (*Important*: refer to **Appendix A**):

- First with caretaker alone (leave child with staff)
- If the WHO, WHAT, WHEN is not clear, and child >3 yr old, interview child without caretaker (bring observer)

The first step is to obtain the history.
Please see Appendix A for history-taking instructions.

- If WHO, WHAT, WHEN are not clear, if possible, briefly interview child without caretaker.
- Have another hospital staff member observe the interview.
- **If the child will not separate from the caregiver, do not interview the child.**



Gathering the History:

First: Leave the child with staff, when possible, and talk with caretaker alone first. Ask the following questions.

- If WHO, WHAT, WHEN are not clear, and child is >3 years old, briefly interview child without caretaker.
  - Have another hospital staff member observe the interview.
- **If the child will not separate from the caregiver, do not interview the child.**

Talk with caretaker alone first (leave child with staff), and ask:

- Why is the caretaker concerned?
  - WHO?
  - WHAT (sexual contact)?
  - WHEN (last possible contact with alleged perpetrator)?
  - Symptoms?
  - Any disclosures by child?
- What words child/family uses for genital/anal area?

If WHO, WHAT, WHEN are not clear, briefly interview child without caretaker. Have another hospital staff member observe the interview:

In all children

- The following are recommendations about how to talk to children about possible child sexual abuse. Use the appropriate category for your patient's age or developmental ability.
- **AVOID**:
  - Coercing or bribing children to talk
  - Asking yes/no, multiple choice, or compound questions
  - Questions that name an action or a person (ie "Did Daddy put his pee-pee in your butt-butt?")
  - Showing shock or disapproval

Pre-School Age Children

- In very young children, often the only information that can be gathered is WHAT happened and WHO did something. Young children cannot reliably report WHEN or timeframes.
- Establish rapport with neutral, child-friendly topics.
- Ask child "what happened?" or "what happened to your _____ (child's name for genitals)."
- To gather more information, say "tell me more about that."
- Document clearly what child tells you in his/her own words.
- Thank child for talking with you.

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How to talk to a Child About Sexual Abuse

- Without parent or caregiver present
- Explain your job is to make sure body is healthy and safe, including whole body, even private parts (use family's word)
- Can utilize these questions:
  - Are you worried about your body?
  - Are you worried about your private part?
  - Is someone else worried about your body/private part?
  - ***TELL ME or TELL ME MORE ABOUT THAT***
  - What part of ___'s body touched your body?
  - What part of your body did _____ touch?
  - Did that happen one time or more than one time?
  - Did that happen today or a different day or something else?

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- Thank child for talking with you.

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Appendix A has further age-specific guidelines for obtaining an accurate history.

It is important to document what the child tells you in his/her own words

School-aged Children

- School-aged children can often provide WHO, WHAT, and some information about WHEN or if there were repeated incidences.
- Establish rapport with neutral, child-friendly topics.
- Ask child "why did you come to the hospital?" or "what happened?" or "what happened to your _____ (child's name for genitals)."
- To gather more information, say "tell me more about that." Do not be afraid to repeat that statement multiple times.
- For timing:
  - Ask child "Did this happen one time or more than one time?"
  - Ask child "tell me about the last time something like this happened." Connect to age of child, or relevant major event (Halloween, birthday party) to determine approximate timing of last contact.
- Document clearly what child tells you in his/her own words.
- Thank the child for talking with you. Reassure child that you will check his/her body and address any concerns.

Adolescents

- Teens can often provide WHO, WHAT, WHEN, and if multiple events occurred. Avoid "why" questions such as "why didn't you tell" or "why did he do that to you?"
- Establish rapport.
- Explain that as a medical provider, you need to know some details about what happened so that you can provide the best medical care for the teen.
- Ask "What happened?" Or "why did you come to the hospital?"
- To gather more information, say "tell me more about that." Do not be afraid to repeat that statement multiple times.
- For timing
  - Ask "Did this happen one time or more than one time?"
  - Ask "Tell me about the last time something like this happened."
- Document clearly what child tells you in his/her own words.
- Thank the teen for talking with you. Reassure teen that you will check his/her body and address any concerns.

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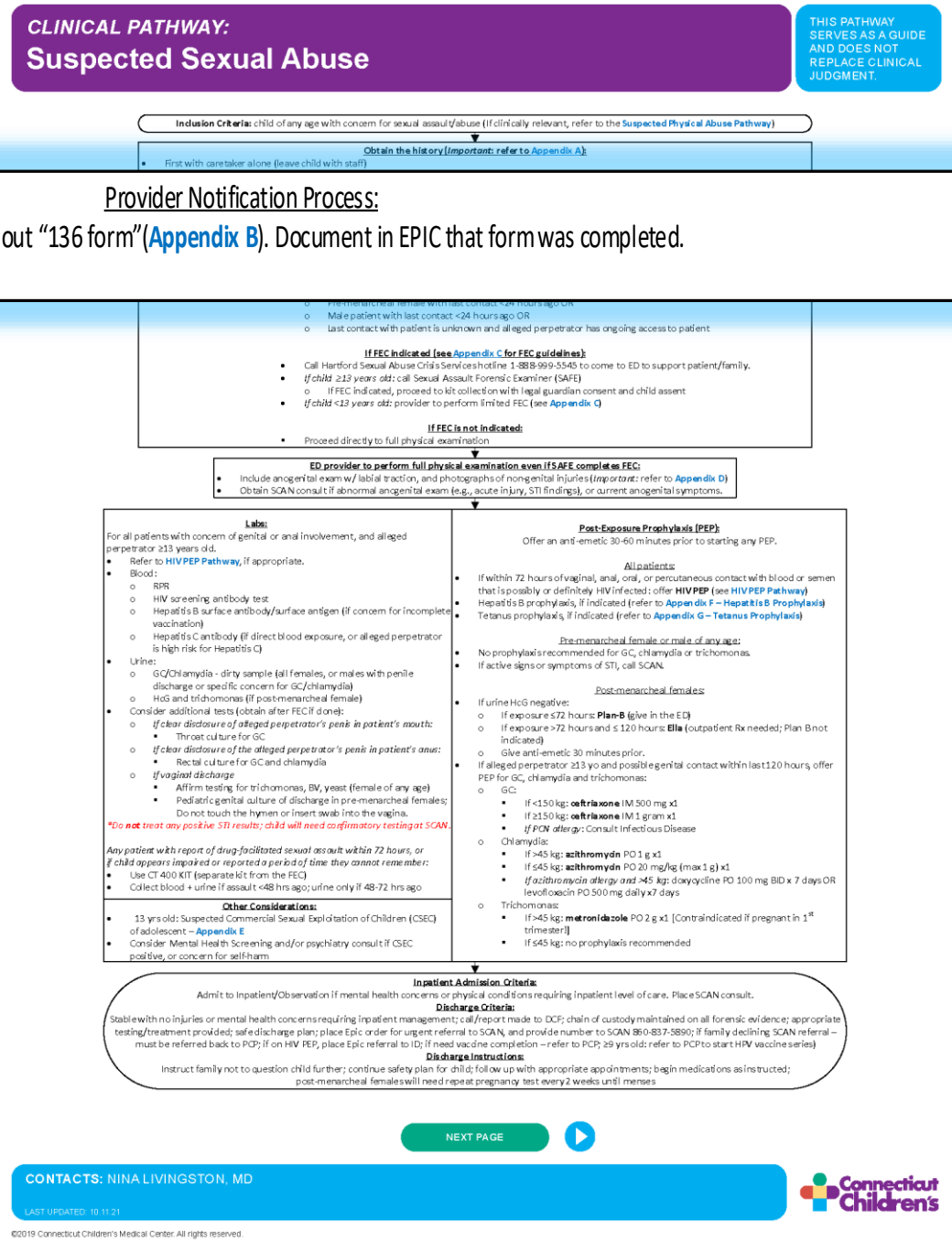
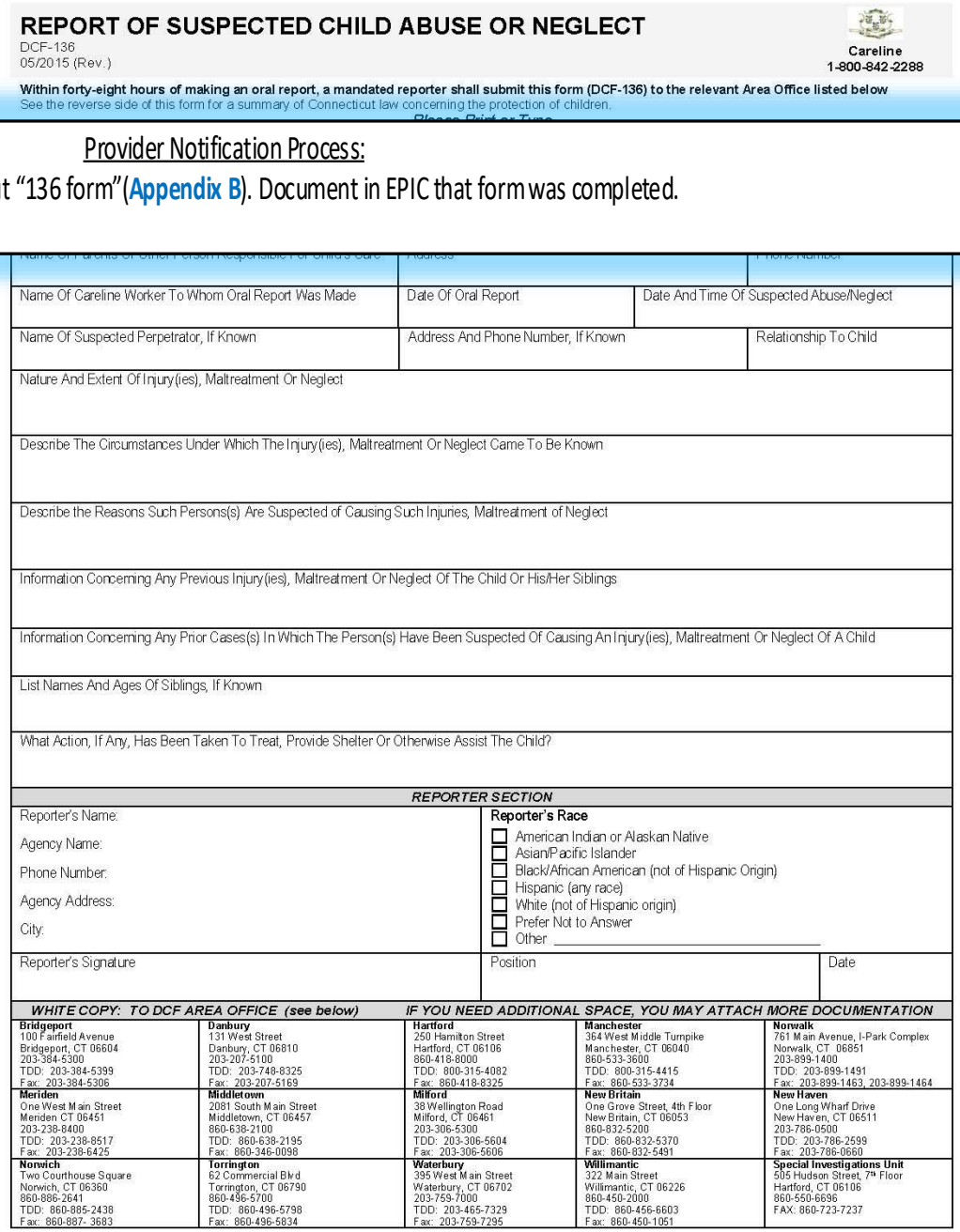
- All providers are mandated reporters, and each case should be reported to DCF as instructed here.
- Contact the ED Social Worker for additional support



Provider Notification Process:

- DCF report: call Careline (860-550-6515) and fill out "136 form"(**Appendix B**). Document in EPIC that form was completed.
- Contact ED Social Worker.

- After calling DCF to report, fill out the "Report of Child Abuse or Neglect (136Form)" which is here as Appendix B
- Document in EPIC form was completed



REPORT OF SUSPECTED CHILD ABUSE OR NEGLECT

DCF-136
05/2015 (Rev.)

Careline
1-800-842-2288

Within forty-eight hours of making an oral report, a mandated reporter shall submit this form (DCF-136) to the relevant Area Office listed below
See the reverse side of this form for a summary of Connecticut law concerning the protection of children.

Please Print or Type

Name Of Parents Or Other Person Responsible For Child's Care	Address	Phone Number
Name Of Careline Worker To Whom Oral Report Was Made	Date Of Oral Report	Date And Time Of Suspected Abuse/Neglect
Name Of Suspected Perpetrator, If Known	Address And Phone Number, If Known	Relationship To Child

Nature And Extent Of Injury(ies), Maltreatment Or Neglect

Describe The Circumstances Under Which The Injury(ies), Maltreatment Or Neglect Came To Be Known

Describe the Reasons Such Persons(s) Are Suspected of Causing Such Injuries, Maltreatment of Neglect

Information Concerning Any Previous Injury(ies), Maltreatment Or Neglect Of The Child Or His/Her Siblings

Information Concerning Any Prior Cases(s) In Which The Person(s) Have Been Suspected Of Causing An Injury(ies), Maltreatment Or Neglect Of A Child

List Names And Ages Of Siblings, If Known

What Action, If Any, Has Been Taken To Treat, Provide Shelter Or Otherwise Assist The Child?

REPORTER SECTION

Reporter's Name: Agency Name: Phone Number: Agency Address: City:	**Reporter's Race** ☐ American Indian or Alaskan Native ☐ Asian/Pacific Islander ☐ Black/African American (not of Hispanic Origin) ☐ Hispanic (any race) ☐ White (not of Hispanic origin) ☐ Prefer Not to Answer ☐ Other _____

Reporter's Signature	Position	Date

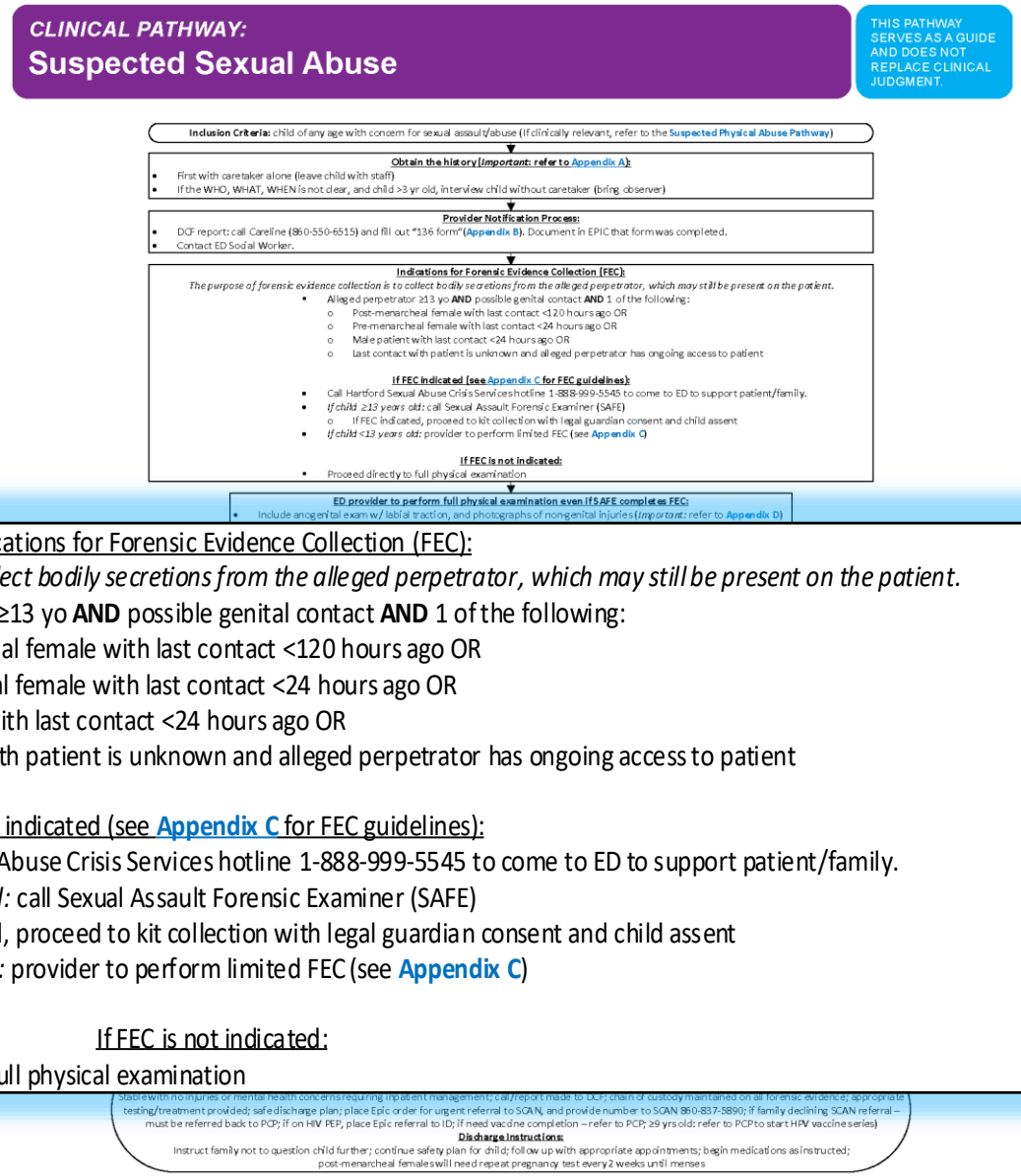
WHITE COPY: TO DCF AREA OFFICE (see below) ***IF YOU NEED ADDITIONAL SPACE, YOU MAY ATTACH MORE DOCUMENTATION***

Bridgeport 100 Fairfield Avenue Bridgeport, CT 06604 203-384-5300 TDD: 203-384-5399 Fax: 203-384-5306	**Danbury** 131 West Street Danbury, CT 06810 203-207-5100 TDD: 203-748-8325 Fax: 203-207-5169	**Hartford** 250 Hamilton Street Hartford, CT 06106 860-418-8000 TDD: 800-315-4082 Fax: 860-418-8325	**Manchester** 364 West Middle Turnpike Manchester, CT 06040 860-533-3600 TDD: 800-315-4415 Fax: 860-533-3734	**Norwalk** 761 Main Avenue, I-Park Complex Norwalk, CT 06851 203-899-1400 TDD: 203-899-1491 Fax: 203-899-1463, 203-899-1464
Meriden One West Main Street Meriden CT 06451 203-238-6400 TDD: 203-238-8517 Fax: 203-238-6425	**Middletown** 2081 South Main Street Middletown, CT 06457 860-638-2100 TDD: 860-638-2195 Fax: 860-346-0098	**Milford** 38 Wellington Road Milford, CT 06461 203-306-5300 TDD: 203-306-5604 Fax: 203-306-5606	**New Britain** One Grove Street, 4th Floor New Britain, CT 06053 860-832-5200 TDD: 860-832-5370 Fax: 860-832-5491	**New Haven** One Long Wharf Drive New Haven, CT 06511 203-786-0500 TDD: 203-786-2599 Fax: 203-786-0660
Norwich Two Courthouse Square Norwich, CT 06360 860-886-2641 TDD: 860-885-2438 Fax: 860-887- 3683	**Torrington** 62 Commercial Blvd Torrington, CT 06790 860-496-5700 TDD: 860-496-5798 Fax: 860-496-5834	**Waterbury** 395 West Main Street Waterbury, CT 06702 203-759-7000 TDD: 203-465-7329 Fax: 203-759-7295	**Willimantic** 322 Main Street Willimantic, CT 06226 860-450-2000 TDD: 860-456-6603 Fax: 860-450-1051	**Special Investigations Unit** 505 Hudson Street, 7th Floor Hartford, CT 06106 860-550-6696 FAX: 860-723-7237

The purpose of the Forensic Evidence FEC is to collect bodily secretions from the alleged perpetrator.

Indications for FEC collections are outlined.

For those <13 years old, providers will perform a limited FEC.



CLINICAL PATHWAY:
Suspected Sexual Abuse

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Inclusion Criteria: child of any age with concern for sexual assault/abuse (if clinically relevant, refer to the Suspected Physical Abuse Pathway)

Obtain the history (*important:* refer to Appendix A):
- First with caretaker alone (leave child with staff)
- If the WHO, WHAT, WHEN is not clear, and child >3 yr old, interview child without caretaker (bring observer)

Provider Notification Process:
- DCF report: call Careline (860-550-6515) and fill out "136 form" (Appendix B). Document in EPIC that form was completed.
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Indications for Forensic Evidence Collection (FEC):

The purpose of forensic evidence collection is to collect bodily secretions from the alleged perpetrator, which may still be present on the patient.

- Alleged perpetrator ≥13 yo **AND** possible genital contact **AND** 1 of the following:
  - Post-menarcheal female with last contact <120 hours ago OR
  - Pre-menarcheal female with last contact <24 hours ago OR
  - Male patient with last contact <24 hours ago OR
  - Last contact with patient is unknown and alleged perpetrator has ongoing access to patient

If FEC indicated (see Appendix C for FEC guidelines):
- Call Hartford Sexual Abuse Crisis Services hotline 1-888-999-5545 to come to ED to support patient/family.
- *If child ≥13 years old:* call Sexual Assault Forensic Examiner (SAFE)
  - If FEC indicated, proceed to kit collection with legal guardian consent and child assent
- *If child <13 years old:* provider to perform limited FEC (see Appendix C)

If FEC is not indicated:
- Proceed directly to full physical examination

ED provider to perform full physical examination even if SAFE completes FEC:
- Include anogenital exam w/ labial traction, and photographs of non-genital injuries (*important:* refer to Appendix D)

stable with no injuries or mental health concerns requiring inpatient management; call/report made to DCF; chain of custody maintained on all forensic evidence; appropriate testing/treatment provided; safe discharge plan; place Epic order for urgent referral to SCAN, and provide number to SCAN 860-837-5890; if family declining SCAN referral – must be referred back to PCP; if on HIV PEP, place Epic referral to ID; if need vaccine completion – refer to PCP; ≥9 yrs old: refer to PCP to start HPV vaccine series)

Discharge Instructions:

Instruct family not to question child further; continue safety plan for child; follow up with appropriate appointments; begin medications as instructed; post-menarcheal females will need repeat pregnancy test every 2 weeks until menses

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Connecticut Children's

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If FEC is not indicated:

- Proceed directly to full physical examination

Appendix C has specific guidelines for the Forensic Evidence Collection (FEC).

Consent guidelines are given and should be reviewed prior to any collection of evidence.

If a full kit evidence is indicated, the collection kit will have specific instructions to follow.

If a limited evidence collection is indicated, then the following steps are outlined in the appendix.

CONSENT

- Per 2017 State of CT Technical Guidelines for Health Care Response to Victims of Sexual Assault (http://www.ct.gov/csao/lib/csao/2017-Technical-Guidelines.pdf), a minor **victim who is 13-17 may present with or without a parent or guardian – one is not required to be present. Staff should attempt to obtain consent from parent or guardian when possible and adolescent agrees to parent notification.** Whether or not such a parent or guardian is present when the minor victim presents - the additional consent of the parent or guardian to the exam and evidence collection is not required and does not need to be obtained in order for the medical/forensic exam and evidence collection to go forward.
- **For child victim age 12 or younger, consent from a parent or guardian should be sought, unless it is suspected that the sole parent/guardian may be the perpetrator, in which case assent from the child (who is capable of doing so) will suffice and parent/guardian consent is not required.**
- Assent should always be obtained from every child who is capable of doing so (verbal will suffice). No child should be forced against his or her will to undergo a sexual assault examination and evidence collection.
- Forensic evidence collection should not be performed on a patient with altered mental status; once mental status returns to normal forensic evidence collection can be performed.
- If parent/guardian refuses to consent and child is believed to be in danger from parent/guardian/other caretaker, DCF should be immediately involved. Attending physician may take the child into custody at the hospital for a period of 96 hours (order must be placed in the medical record indicating a 96 hour hold was placed for medical evaluation of an abuse concern), which allows health care personnel to provide immediate assessment, diagnosis, and treatment. If a 96 hour hold is placed by attending physician, the on-call administrator should be notified.

FULL KIT EVIDENCE COLLECTION:
For post-pubertal/post-menarcheal children, complete full evidence collection kit per kit instructions

- Sexual Assault Forensic Examiners available for ≥ 13 yrs old
- If SAFE not available, ED providers will perform evidence collection.

LIMITED EVIDENCE COLLECTION:
For pre-pubertal/pre-menarcheal children, use the Full Forensic Evidence Collection Kit but only perform the following steps:

First open kit and be sure to **wear gloves**.

- Complete paperwork included in kit*
- **DO NOT** pluck head or pubic hair; this can be done later if necessary
- Collect clothing – Collect outer clothing if it is the same clothing worn during the assault. Collect underpants even if not the same pair worn during the assault.
    a. Use 1 large bag labeled ***Clothing***, small bags labeled ***Outer Clothing*** (if indicated) and 1 small bag labeled ***Underpants***. Follow directions on the large

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If a limited evidence collection is indicated, then the following steps are outlined in the appendix.

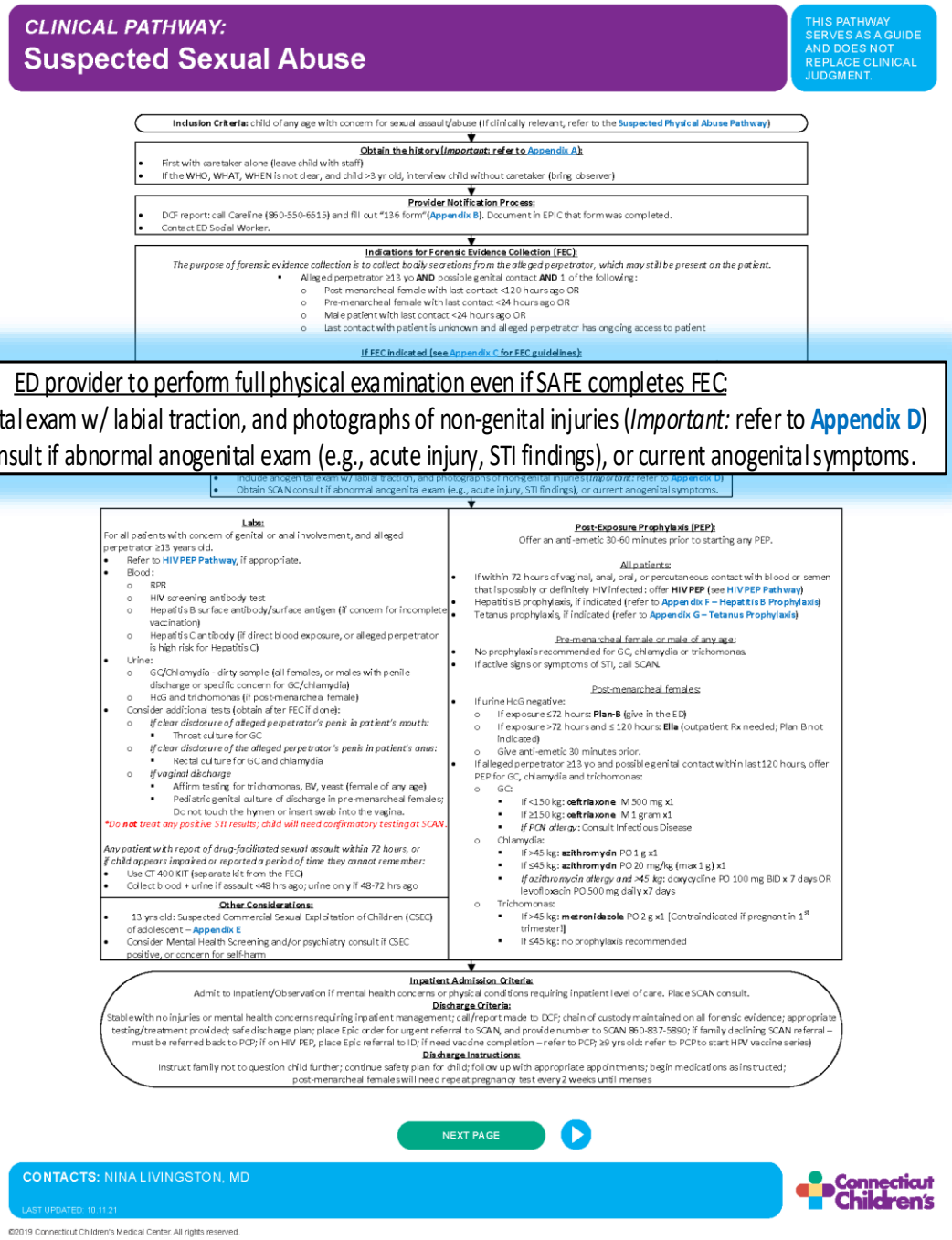
bag labeled ***Clothing*** for direction on how to properly collect each article of clothing.

- Collect debris if present – Use envelope labeled ***Debris Collection***.
- Collect oral swabs – Use envelope labeled ***Oral Swabs and Smear.***
- Collect swabs of areas that fluoresce with alternate light source – Use envelope labeled ***Dried Secretion Specimen.***
- Collect "Touch DNA" swabs if indicated (Touch DNA can be collected if child was strangled or forcefully grabbed) – Once swabs are collected, seal and label envelope in accordance with instructions of ***Evidence Integrity***
- FEMALES:
  a. Collect 2 ***genital swabs*** from outer surface of the entire labial area.
  b. Collect 2 ***genital swabs*** between the labia.
  c. **DO NOT SWAB ON THE HYMEN OR INTO THE VAGINA AS THIS CAN BE PAINFUL. DO NOT USE A SPECULUM**. Use envelope labeled ***Genital Swab***, and use all four swabs if possible.
  d. Collect anal swabs from the anal cavity/rectum - Use envelope labeled ***Anal Swabs and Smear***.
- MALES:
  a. Collect 4 ***genital swabs*** from penis, scrotum, and perineum
  b. Collect anal swabs from the anal cavity/rectum - Use envelope labeled ***Anal Swabs and Smear***.

*** Be sure to put the yellow copy of the completed "State of CT Sexual Assault Medical Report" in the envelope glued to the underside of the forensic kit box.**

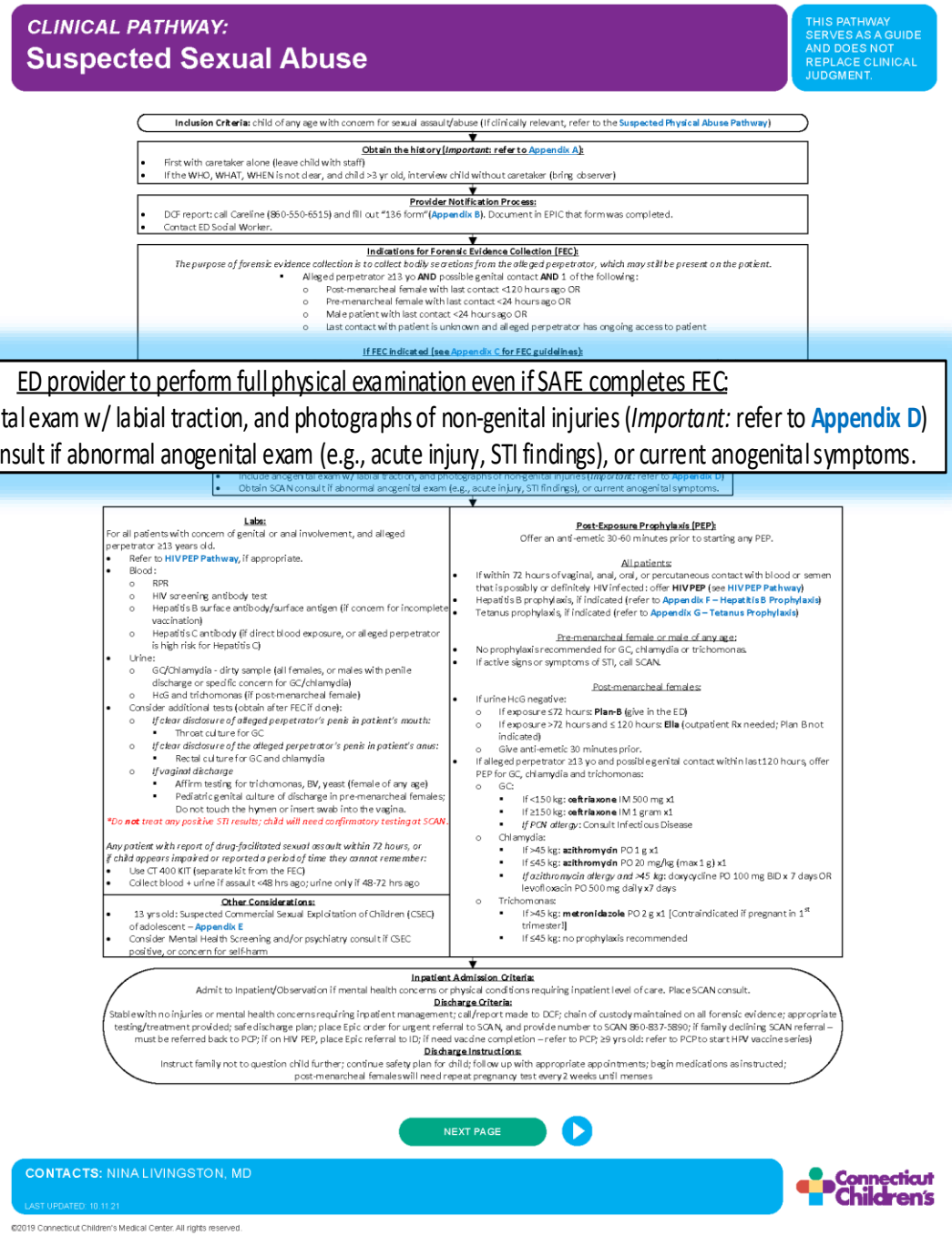
After the FEC is complete, the ED provider is still to complete a full physical examination that includes an anogenital exam.

Appendix D provides tips for genital examinations.



Remember that the most common finding in a sexual abuse evaluation is a **normal** exam.

Classification of any physical findings is reviewed in the next slide.



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- DCF report: call Careline (860-550-6515) and fill out "136 form" (Appendix B). Document in EPIC that form was completed.
- Contact ED Social Worker.

Indications for Forensic Evidence Collection (FEC):
The purpose of forensic evidence collection is to collect bodily secretions from the alleged perpetrator, which may still be present on the patient.
- Alleged perpetrator ≥13 yo **AND** possible genital contact **AND** 1 of the following:
  - Post-menarcheal female with last contact <120 hours ago OR
  - Pre-menarcheal female with last contact <24 hours ago OR
  - Male patient with last contact <24 hours ago OR
  - Last contact with patient is unknown and alleged perpetrator has ongoing access to patient

If FEC indicated (see Appendix C for FEC guidelines):

ED provider to perform full physical examination even if SAFE completes FEC:
- Include anogenital exam w/ labial traction, and photographs of non-genital injuries (*Important:* refer to Appendix D)
- Obtain SCAN consult if abnormal anogenital exam (e.g., acute injury, STI findings), or current anogenital symptoms.

- Include anogenital exam w/ labial traction, and photographs of non-genital injuries (*Important:* refer to Appendix D)
- Obtain SCAN consult if abnormal anogenital exam (e.g., acute injury, STI findings), or current anogenital symptoms.

Labs:
For all patients with concern of genital or anal involvement, and alleged perpetrator ≥13 years old.
- Refer to HIV PEP Pathway, if appropriate.
- Blood:
  - RPR
  - HIV screening antibody test
  - Hepatitis B surface antibody/surface antigen (if concern for incomplete vaccination)
  - Hepatitis C antibody (if direct blood exposure, or alleged perpetrator is high risk for Hepatitis C)
- Urine:
  - GC/Chlamydia - dirty sample (all females, or males with penile discharge or specific concern for GC/chlamydia)
  - HcG and trichomonas (if post-menarcheal female)
- Consider additional tests (obtain after FEC if done):
  - *If clear disclosure of alleged perpetrator's penile in patient's mouth:*
    - Throat culture for GC
  - *If clear disclosure of the alleged perpetrator's penile in patient's anus:*
    - Rectal culture for GC and chlamydia
  - *If vaginal discharge*
    - Affirm testing for trichomonas, BV, yeast (female of any age)
    - Pediatric genital culture of discharge in pre-menarcheal females; Do not touch the hymen or insert swab into the vagina.

Do **not treat any positive STI results; child will need confirmatory testing at SCAN.*

Any patient with report of drug-facilitated sexual assault within 72 hours, or if child appears impaired or reported a period of time they cannot remember:
- Use CT 400 KIT (separate kit from the FEC)
- Collect blood + urine if assault <48 hrs ago; urine only if 48-72 hrs ago

Other Considerations:
- 13 yrs old: Suspected Commercial Sexual Exploitation of Children (CSEC) of adolescent – Appendix E
- Consider Mental Health Screening and/or psychiatry consult if CSEC positive, or concern for self-harm

Post-Exposure Prophylaxis (PEP):
Offer an anti-emetic 30-60 minutes prior to starting any PEP.

All patients:
- If within 72 hours of vaginal, anal, oral, or percutaneous contact with blood or semen that is possibly or definitely HIV infected: offer **HIV PEP** (see HIV PEP Pathway)
- Hepatitis B prophylaxis, if indicated (refer to **Appendix F – Hepatitis B Prophylaxis**)
- Tetanus prophylaxis, if indicated (refer to **Appendix G – Tetanus Prophylaxis**)

Pre-menarcheal female or male of any age:
- No prophylaxis recommended for GC, chlamydia or trichomonas.
- If active signs or symptoms of STI, call SCAN.

Post-menarcheal females:
- If urine HcG negative:
  - If exposure ≤72 hours: **Plan-B** (give in the ED)
  - If exposure >72 hours and ≤ 120 hours: **Ella** (outpatient Rx needed; Plan B not indicated)
  - Give anti-emetic 30 minutes prior.
- If alleged perpetrator ≥13 yo and possible genital contact within last 120 hours, offer PEP for GC, chlamydia and trichomonas:
  - GC:
    - If <150 kg: **ceftriaxone** IM 500 mg x1
    - If ≥150 kg: **ceftriaxone** IM 1 gram x1
    - *If PCN allergy:* Consult Infectious Disease
  - Chlamydia:
    - If >45 kg: **azithromydn** PO 1 g x1
    - If ≤45 kg: **azithromydn** PO 20 mg/kg (max 1 g) x1
    - *If azithromycin allergy and >45 kg:* doxycycline PO 100 mg BID x 7 days OR levofloxacin PO 500 mg daily x7 days
  - Trichomonas:
    - If >45 kg: **metronidazole** PO 2 g x1 [Contraindicated if pregnant in 1st trimester!]
    - If ≤45 kg: no prophylaxis recommended

Inpatient Admission Criteria:
Admit to Inpatient/Observation if mental health concerns or physical conditions requiring inpatient level of care. Place SCAN consult.

Discharge Criteria:
Stable with no injuries or mental health concerns requiring inpatient management; call/report made to DCF; chain of custody maintained on all forensic evidence; appropriate testing/treatment provided; safe discharge plan; place Epic order for urgent referral to SCAN, and provide number to SCAN 860-837-5890; if family declining SCAN referral – must be referred back to PCP; if on HIV PEP, place Epic referral to ID; if need vaccine completion – refer to PCP; ≥9 yrs old: refer to PCP to start HPV vaccine series)

Discharge Instructions:
Instruct family not to question child further; continue safety plan for child; follow up with appropriate appointments; begin medications as instructed; post-menarcheal females will need repeat pregnancy test every 2 weeks until menses

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CONTACTS: NINA LIVINGSTON, MD

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Connecticut Children's

Classification of Physical Findings

Normal/Non-Specific Findings

- Normal variants of the hymen
- Any notch or cleft in the hymen above the 3 or 9 o'clock location
- Periurethral bands
- Intravaginal ridges or columns
- Diastasis ani
- Perianal skin tags
- Dilation of the urethral opening
- Erythema of the anal or genital tissues
- Labial adhesion
- Vaginal discharge not associated with an STI
- Anal fissures

Indeterminate Findings

- Posterior deep notch of the hymen, but is not a complete transection
- Complete cleft or suspected transection to the base of the hymen at 3 or 9 o'clock
- Complete anal dilation with relaxation of the internal as well as external anal sphincters in the absence of constipation, encopresis, sedation, anesthesia, or neuromuscular disorders

Positive Findings

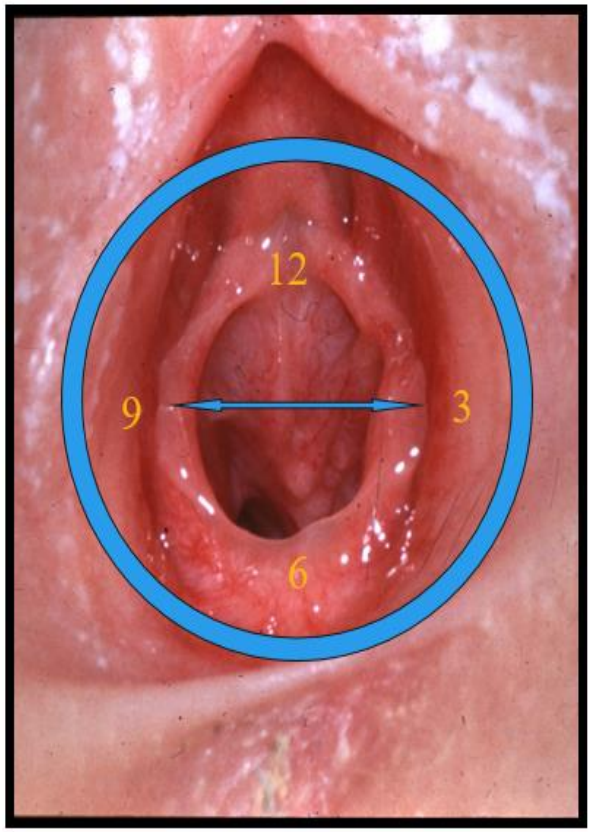
- Acute lacerations or bruising to the labia, penis, scrotum or perineum
- Acute laceration to the posterior fourchette or vestibule, not involving the hymen
- Bruising, petechiae or abrasions on the hymen
- Acute laceration of the hymen
- Vaginal laceration
- Perianal laceration with exposure of tissues below the dermis
- Residual or healing injuries to the genitals or anus (scars) including healed hymenal transections below 3 and 9 o'clock with no discernible hymenal tissue at that location

Adams JA et al. Interpretation of medical findings in suspected child sexual abuse: an update for 2018

For females, it is recommended NOT to use a speculum.

FEMALES:

- Do NOT use a speculum!
- Pre-pubertal girls:
  - Involve Child Life Specialists.
  - Can be examined supine in frog leg position or on caretaker's lap.
  - Use gentle labial traction *(gently pull outward and lateral on the labia minora)* to expose structures of interest in females.
  - As the child relaxes, the hymen will relax and the opening should be visible.
  - Do not document "hymen intact" (even though this is a check box option in Epic) as this terminology is incorrect.



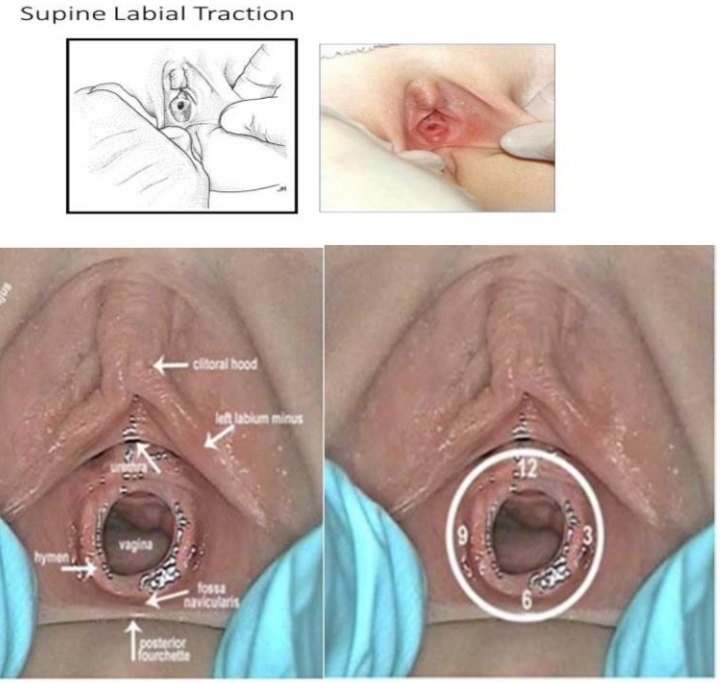
Anterior

Above 9-3 o'clock has normal anatomic variability

Posterior

Abnormalities are significant

Normal Female Prepubertal Anatomy in Labial Traction



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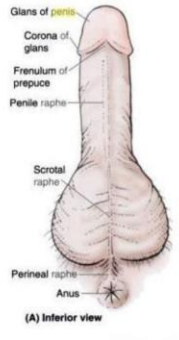
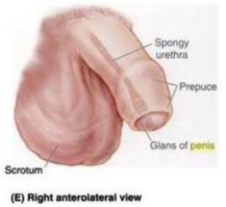
Normal male anatomy is also reviewed in Appendix D.

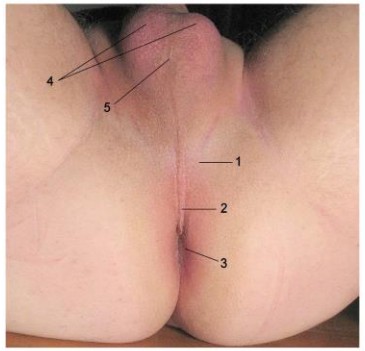
MALES:

- Involve Child Life Specialists.
- Can be examined supine on table, then with knees to chest, or on caregiver's lap.

Normal Male Anatomy







1. Perineum. 2. Raphe perinealis. 3. Anus. 4. Testicles, Scrotum. 5. Raphe scrotalis

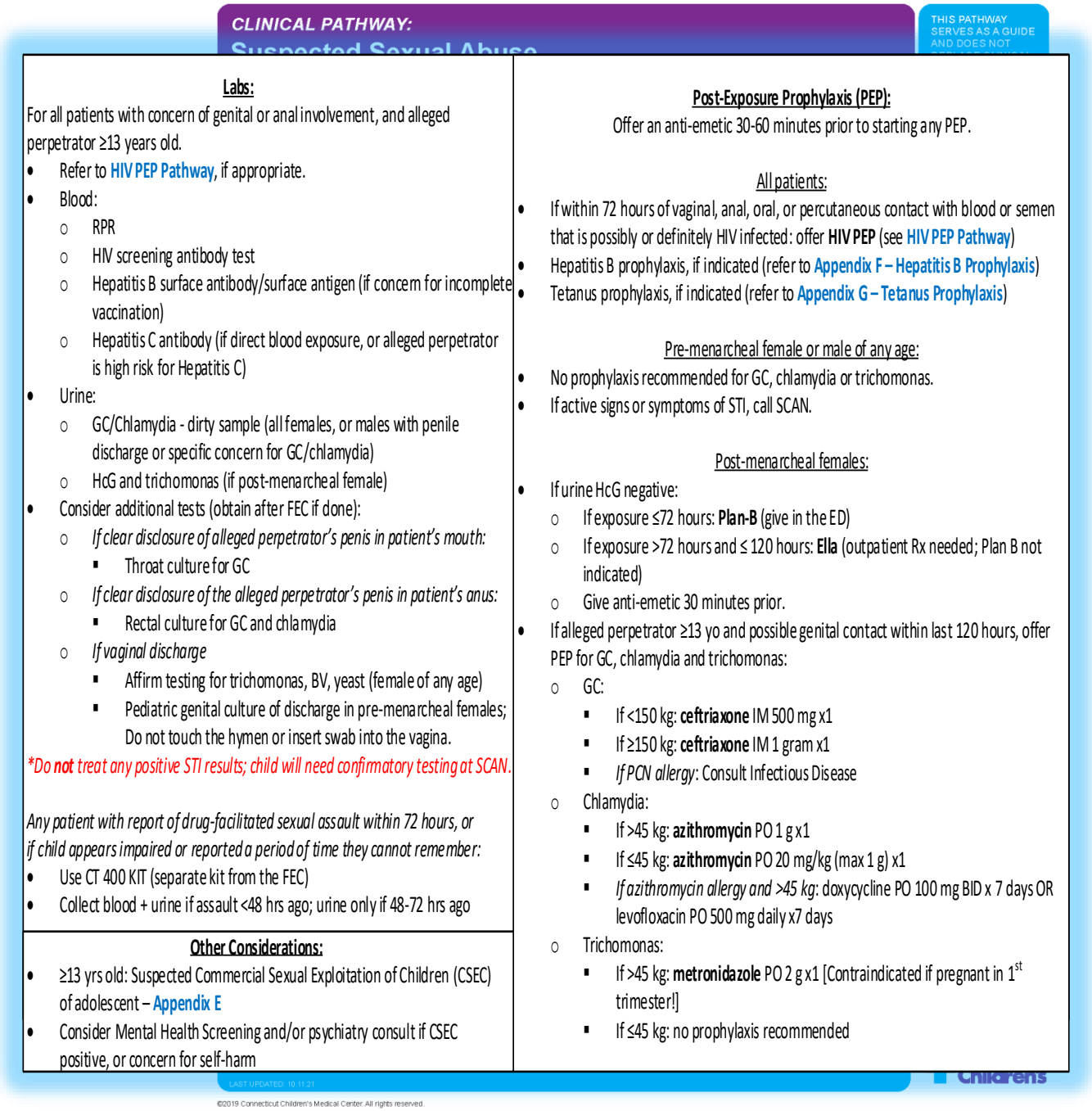
FEMALES AND MALES:

- Anus best examined with child on back with knees held to chest (like a "cannonball"). Document any irregularities or lesions by superimposing a clock face with 12 anterior (similar to hymen diagram).
- Documentation:
  - Use Epic diagram under GU exam to help document.

Guidelines on steps to take in certain situations are also given.

  - Only use words for structures you can identify. Otherwise, use drawing tools or numbers in Epic to indicate areas of injury or concern. For example, do not document “vaginal laceration” if the area is on the labia.
  - If injury present, document location using a clock face (see hyman diagram above).
- If patient refuses or is not cooperative with genital examination:
  - Defer examination and refer the child to SCAN for follow-up.
- If physical is urgent (e.g., there is pain or bleeding):
  - Involve Child Life Specialists.
  - In rare cases, sedation or anesthesia may be necessary.
  - Consult gynecology and/or trauma surgical team if blood coming from vagina/anus, or if exam under anesthesia is being considered.
- If abnormal genital findings are felt to be related to abuse/assault:
  - Notify SCAN team:
    - 860-837-5890 during weekday hours.
    - Or page SCAN provider on-call via Intellidesk.

After the examination, further work up and Post-Exposure Prophylaxis (PEP) should be initiated.



CLINICAL PATHWAY:
Suspected Sexual Abuse

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT

Labs:

For all patients with concern of genital or anal involvement, and alleged perpetrator ≥13 years old.

- Refer to HIV PEP Pathway, if appropriate.
- Blood:
  - RPR
  - HIV screening antibody test
  - Hepatitis B surface antibody/surface antigen (if concern for incomplete vaccination)
  - Hepatitis C antibody (if direct blood exposure, or alleged perpetrator is high risk for Hepatitis C)
- Urine:
  - GC/Chlamydia - dirty sample (all females, or males with penile discharge or specific concern for GC/chlamydia)
  - HcG and trichomonas (if post-menarcheal female)
- Consider additional tests (obtain after FEC if done):
  - *If clear disclosure of alleged perpetrator's penis in patient's mouth:*
    - Throat culture for GC
  - *If clear disclosure of the alleged perpetrator's penis in patient's anus:*
    - Rectal culture for GC and chlamydia
  - *If vaginal discharge*
    - Affirm testing for trichomonas, BV, yeast (female of any age)
    - Pediatric genital culture of discharge in pre-menarcheal females; Do not touch the hymen or insert swab into the vagina.

Do **not treat any positive STI results; child will need confirmatory testing at SCAN.*

Any patient with report of drug-facilitated sexual assault within 72 hours, or if child appears impaired or reported a period of time they cannot remember:

- Use CT 400 KIT (separate kit from the FEC)
- Collect blood + urine if assault <48 hrs ago; urine only if 48-72 hrs ago

Other Considerations:

- ≥13 yrs old: Suspected Commercial Sexual Exploitation of Children (CSEC) of adolescent – Appendix E
- Consider Mental Health Screening and/or psychiatry consult if CSEC positive, or concern for self-harm

Post-Exposure Prophylaxis (PEP):

Offer an anti-emetic 30-60 minutes prior to starting any PEP.

All patients:

- If within 72 hours of vaginal, anal, oral, or percutaneous contact with blood or semen that is possibly or definitely HIV infected: offer **HIV PEP** (see HIV PEP Pathway)
- Hepatitis B prophylaxis, if indicated (refer to Appendix F – Hepatitis B Prophylaxis)
- Tetanus prophylaxis, if indicated (refer to Appendix G – Tetanus Prophylaxis)

Pre-menarcheal female or male of any age:

- No prophylaxis recommended for GC, chlamydia or trichomonas.
- If active signs or symptoms of STI, call SCAN.

Post-menarcheal females:

- If urine HcG negative:
  - If exposure ≤72 hours: **Plan-B** (give in the ED)
  - If exposure >72 hours and ≤ 120 hours: **Ella** (outpatient Rx needed; Plan B not indicated)
  - Give anti-emetic 30 minutes prior.
- If alleged perpetrator ≥13 yo and possible genital contact within last 120 hours, offer PEP for GC, chlamydia and trichomonas:
  - GC:
    - If <150 kg: **ceftriaxone** IM 500 mg x1
    - If ≥150 kg: **ceftriaxone** IM 1 gram x1
    - *If PCN allergy*: Consult Infectious Disease
  - Chlamydia:
    - If >45 kg: **azithromycin** PO 1 g x1
    - If ≤45 kg: **azithromycin** PO 20 mg/kg (max 1 g) x1
    - *If azithromycin allergy and >45 kg*: doxycycline PO 100 mg BID x 7 days OR levofloxacin PO 500 mg daily x7 days
  - Trichomonas:
    - If >45 kg: **metronidazole** PO 2 g x1 [Contraindicated if pregnant in 1st trimester!]
    - If ≤45 kg: no prophylaxis recommended

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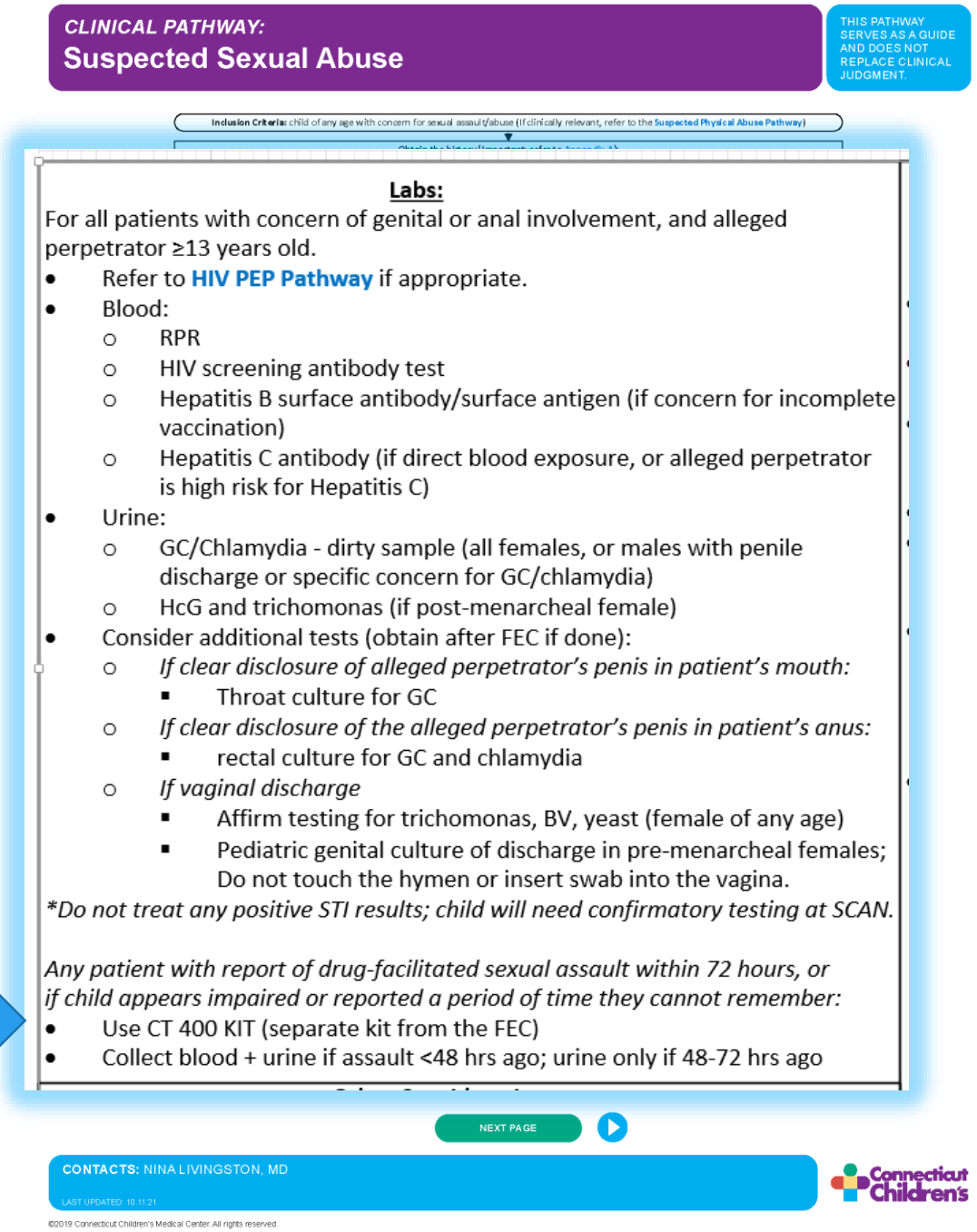
Children's

If there is any concern for genital or anal involvement, and if the alleged perpetrator is ≥13 years old, then further work up is indicated.

Work up for sexually transmitted infections are listed here.

Note: if STI testing is positive, do not treat. The child will need confirmatory testing at SCAN.

If there seems to be drug involvement, the CT 400 KIT should be completed, in addition to the FEC.



CLINICAL PATHWAY:
Suspected Sexual Abuse

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Inclusion Criteria: child of any age with concern for sexual assault/abuse (if clinically relevant, refer to the Suspected Physical Abuse Pathway)

Labs:

For all patients with concern of genital or anal involvement, and alleged perpetrator ≥13 years old.

- Refer to **HIV PEP Pathway** if appropriate.
- Blood:
  - RPR
  - HIV screening antibody test
  - Hepatitis B surface antibody/surface antigen (if concern for incomplete vaccination)
  - Hepatitis C antibody (if direct blood exposure, or alleged perpetrator is high risk for Hepatitis C)
- Urine:
  - GC/Chlamydia - dirty sample (all females, or males with penile discharge or specific concern for GC/chlamydia)
  - HcG and trichomonas (if post-menarcheal female)
- Consider additional tests (obtain after FEC if done):
  - *If clear disclosure of alleged perpetrator's penis in patient's mouth:*
    - Throat culture for GC
  - *If clear disclosure of the alleged perpetrator's penis in patient's anus:*
    - rectal culture for GC and chlamydia
  - *If vaginal discharge*
    - Affirm testing for trichomonas, BV, yeast (female of any age)
    - Pediatric genital culture of discharge in pre-menarcheal females; Do not touch the hymen or insert swab into the vagina.

**Do not treat any positive STI results; child will need confirmatory testing at SCAN.*

Any patient with report of drug-facilitated sexual assault within 72 hours, or if child appears impaired or reported a period of time they cannot remember:

- Use CT 400 KIT (separate kit from the FEC)
- Collect blood + urine if assault <48 hrs ago; urine only if 48-72 hrs ago

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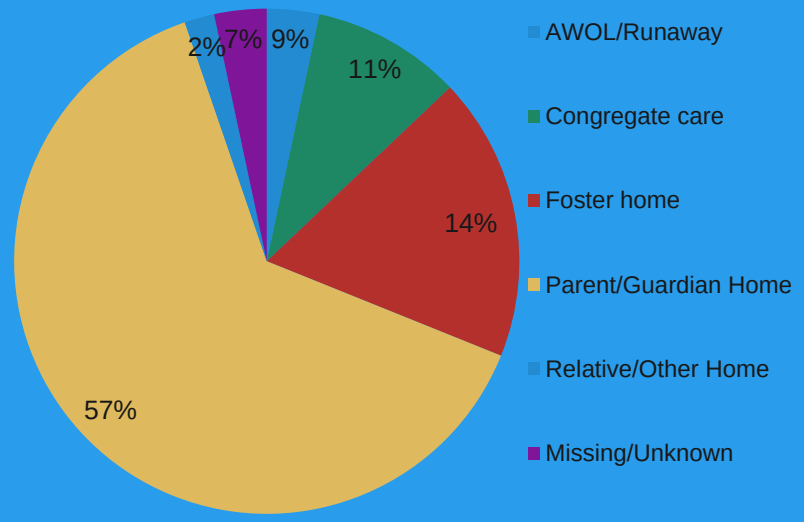
Connecticut Children's

It is important to also consider potential CSEC. Appendix E is the Greenbaum Screening Tool.

The demographic of CSEC is not the stereotypical runaway.

The majority of CSEC live at home, and only 9% are AWOL/runaways.

Residence at Time of Exploitation



CLINICAL PATHWAY:
Suspected Sexual Abuse

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Inclusion Criteria: child of any age with concern for sexual assault/abuse (if clinically relevant, refer to the Suspected Physical Abuse Pathway)

Obtain the history (*Important:* refer to Appendix A):
- First with caretaker alone (leave child with staff)
- If the WHO, WHAT, WHEN is not clear, and child ≥3 yr old, interview child without caretaker (bring observer)

Other Considerations:

- ≥13 yrs old: Suspected Commercial Sexual Exploitation of Children (CSEC) of adolescent – **Appendix E**
- Consider Mental Health Screening and/or psychiatry consult if CSEC positive, or concern for self-harm

If FEC is not indicated:
- Proceed directly to full physical examination

ED provider to perform full physical examination even if SAFE completes FEC:
- Include anogenital exam w/ labial traction, and photographs of non-genital injuries (*Important:* refer to Appendix D)
- Obtain SCAN consult if abnormal anogenital exam (e.g., acute injury, STI findings), or current anogenital symptoms.

Labs:
For all patients with concern of genital or anal involvement, and alleged perpetrator ≥13 years old.
- Refer to HIV PEP Pathway, if appropriate.

Post-Exposure Prophylaxis (PEP):
Offer an anti-emetic 30-60 minutes prior to starting any PEP.

All patients:

For patients ≥13 years old:
Greenbaum Screening Tool

- Is there a previous history of drug and/or alcohol use?
- Has the youth ever run away from home?
- Has the youth ever been involved with law enforcement?
- Has the youth ever broken a bone, had traumatic loss of consciousness, or sustained a significant wound?
- Has the youth ever had a sexually transmitted infection?
- Does the youth have a history of sexual activity with more than 5 partners?

Results:
- 2 or more positive answers is a positive screen.
- If positive, inform DCF and arrange a formal mental health evaluation. Consider child a possible flight risk.

Discharge Instructions:
Instruct family not to question child further; continue safety plan for child; follow up with appropriate appointments; begin medications as instructed; post-menarcheal females will need repeat pregnancy test every 2 weeks until menses

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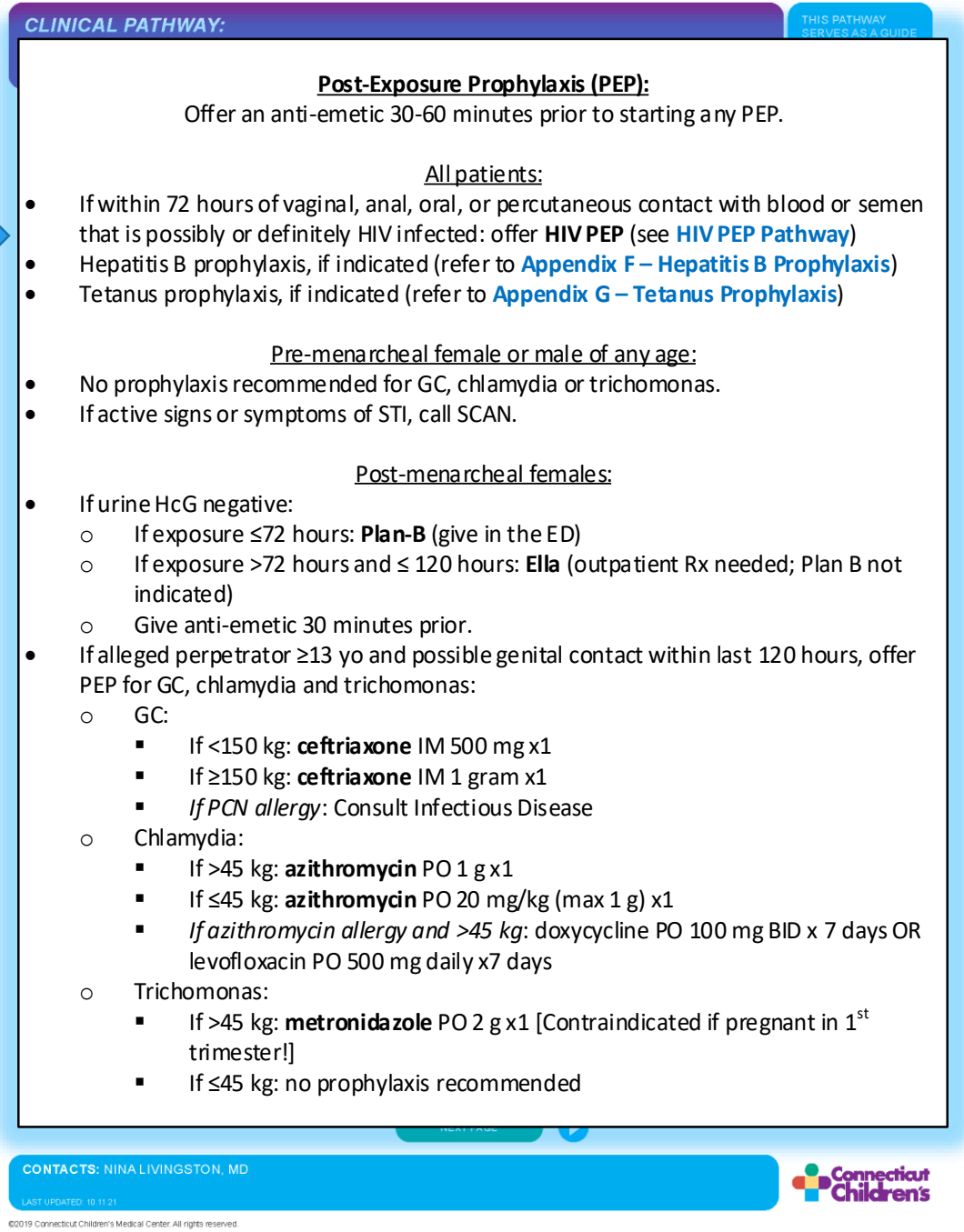
Specific PEP guidelines are listed here.

HIV PEP should be offered if the contact occurred within 72 hours, and it was possibly (or definitely) HIV infected.

The link to the HIV PEP clinical pathway is provided.



CLINICAL PATHWAY:

THIS PATHWAY SERVES AS A GUIDE

Post-Exposure Prophylaxis (PEP):

Offer an anti-emetic 30-60 minutes prior to starting any PEP.

All patients:

- If within 72 hours of vaginal, anal, oral, or percutaneous contact with blood or semen that is possibly or definitely HIV infected: offer **HIV PEP** (see **HIV PEP Pathway**)
- Hepatitis B prophylaxis, if indicated (refer to **Appendix F – Hepatitis B Prophylaxis**)
- Tetanus prophylaxis, if indicated (refer to **Appendix G – Tetanus Prophylaxis**)

Pre-menarcheal female or male of any age:

- No prophylaxis recommended for GC, chlamydia or trichomonas.
- If active signs or symptoms of STI, call SCAN.

Post-menarcheal females:

- If urine HcG negative:
  - If exposure ≤72 hours: **Plan-B** (give in the ED)
  - If exposure >72 hours and ≤ 120 hours: **Ella** (outpatient Rx needed; Plan B not indicated)
  - Give anti-emetic 30 minutes prior.
- If alleged perpetrator ≥13 yo and possible genital contact within last 120 hours, offer PEP for GC, chlamydia and trichomonas:
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    - If <150 kg: **ceftriaxone** IM 500 mg x1
    - If ≥150 kg: **ceftriaxone** IM 1 gram x1
    - *If PCN allergy*: Consult Infectious Disease
  - Chlamydia:
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    - *If azithromycin allergy and >45 kg*: doxycycline PO 100 mg BID x 7 days OR levofloxacin PO 500 mg daily x7 days
  - Trichomonas:
    - If >45 kg: **metronidazole** PO 2 g x1 [Contraindicated if pregnant in 1st trimester!]
    - If ≤45 kg: no prophylaxis recommended

CONTACTS: NINA LIVINGSTON, MD

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Connecticut Children's

Specific PEP guidelines are listed here.

Indications for hepatitis B post-exposure prophylaxis is provided in Appendix F.

CLINICAL PATHWAY:

THIS PATHWAY SERVES AS A GUIDE

Post-Exposure Prophylaxis (PEP):

Offer an anti-emetic 30-60 minutes prior to starting any PEP.

All patients:

- If within 72 hours of vaginal, anal, oral, or percutaneous contact with blood or semen that is possibly or definitely HIV infected: offer **HIV PEP** (see **HIV PEP Pathway**)
- Hepatitis B prophylaxis, if indicated (refer to **Appendix F – Hepatitis B Prophylaxis**)

CLINICAL PATHWAY:
Suspected Sexual Abuse
Appendix F: Hepatitis B Prophylaxis

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Hepatitis B: Post-exposure Immunoprophylaxis

Immunoprophylaxis should be administered as soon as possible (preferably within 24 hours) or within 7 days of percutaneous exposure.

Exposure	Hepatitis B Prophylaxis Management	
	Unvaccinated Person	Previously Vaccinated Person
HBsAg-positive source	Hep B vaccine series[1] and HBIG	Hep B vaccine dose[1]
HBsAg status unknown for source	Hep B vaccine series[1]	No management

Abbreviations: Hep B = hepatitis B; HBsAg = hepatitis B surface antigen; HBIG = hepatitis B immune globulin.

[1]Hepatitis B lifetime vaccination maximum is 6 doses.

Specific PEP guidelines are listed here.

Indications for tetanus prophylaxis (and how to administer TIG) is given in appendix G.

Post-Exposure Prophylaxis (PEP):
Offer an anti-emetic 30-60 minutes prior to starting any PEP.

All patients:

- If within 72 hours of vaginal, anal, oral, or percutaneous contact with blood or semen that is possibly or definitely HIV infected: offer **HIV PEP** (see **HIV PEP Pathway**)
- Hepatitis B prophylaxis, if indicated (refer to **Appendix F – Hepatitis B Prophylaxis**)
- Tetanus prophylaxis, if indicated (refer to **Appendix G – Tetanus Prophylaxis**)

CLINICAL PATHWAY:
Suspected Sexual Abuse
Appendix G: Tetanus Prophylaxis

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Guide to Tetanus Prophylaxis in Routine Wound Management

History of Adsorbed Tetanus Toxoid (Doses)	Clean, Minor Wounds		All Other Wounds [a]	
	DTaP, Tdap, or Td [b]	TIG [c]	DTaP, Tdap, or Td [b]	TIG [c]
Fewer than 3 or unknown	Yes	No	Yes	Yes
3 or more	No if <10 y since last tetanus-containing vaccine dose	No	No [d] if <5 y since last tetanus-containing vaccine dose	No
	Yes if ≥10 y since last tetanus-containing vaccine dose	No	Yes if ≥5 y since last tetanus-containing vaccine dose	No

Tdap indicates booster tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine; DTaP, diphtheria and tetanus toxoids and acellular pertussis vaccine; Td, adult-type diphtheria and tetanus toxoids vaccine; TIG, Tetanus Immune Globulin (human).
[a]Such as, but not limited to, wounds contaminated with dirt, feces, soil, and saliva (eg, following animal bites); puncture wounds; avulsions; and wounds resulting from missiles, crushing, burns, and frostbite.
[b]DTaP is used for children younger than 7 years. Tdap is preferred over Td for underimmunized children 7 years and older who have not received Tdap previously.
[c]Immune Globulin Intravenous should be used when TIG is not available.
[d]More frequent boosters are not needed and can accentuate adverse effects.

American Academy of Pediatrics. Wound Care and Tetanus Prophylaxis. In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2018 Report of the Committee on Infectious Diseases*. American Academy of Pediatrics; 2018; 186

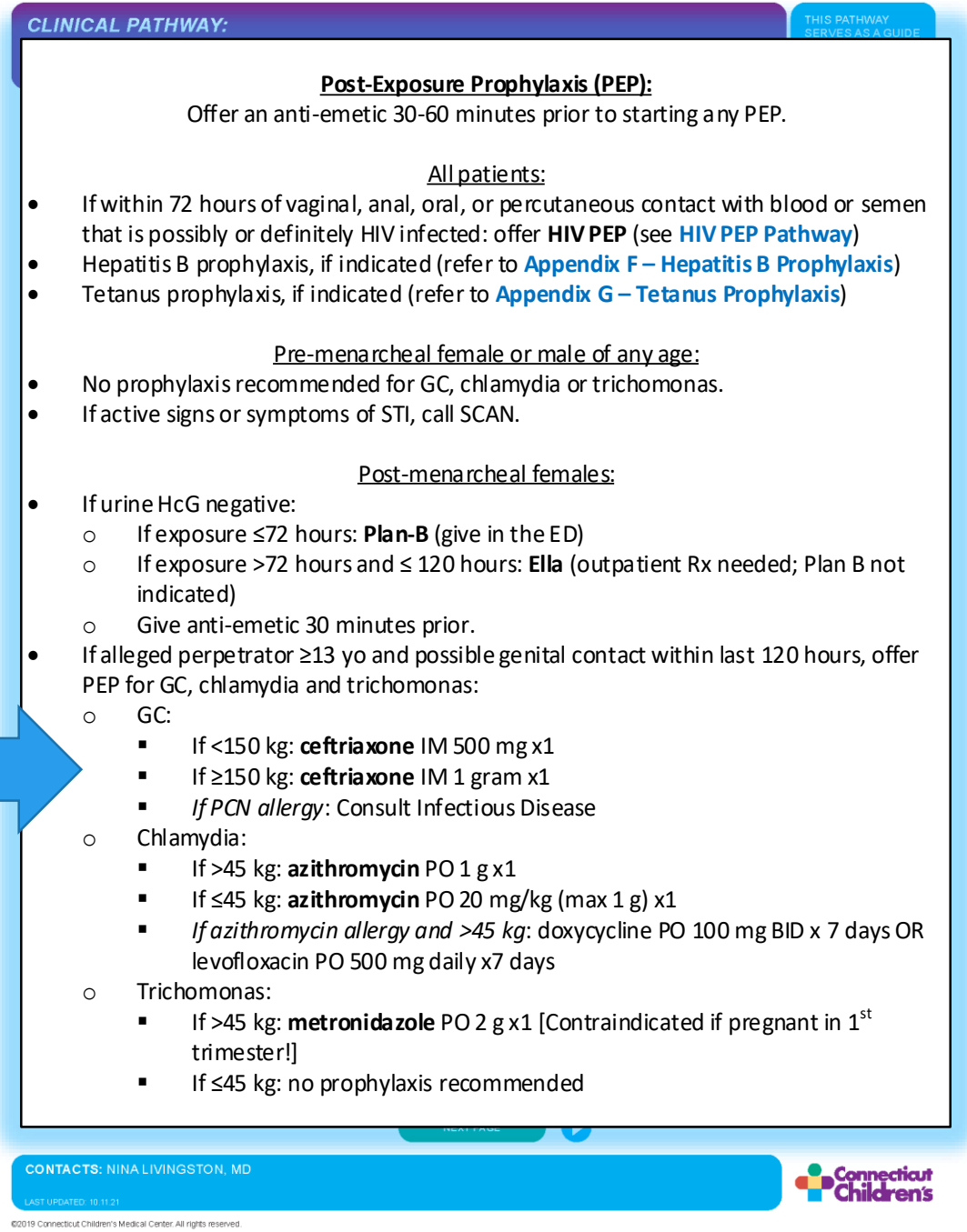
TETANUS IMMUNE GLOBULIN (TIG)[c]

- When TIG is required for wound prophylaxis, it is administered intramuscularly in a dose of 250 U (regardless of age or weight).
- If tetanus toxoid vaccine and TIG are administered concurrently, separate syringes and sites should be used.

Specific PEP guidelines are listed here.

Note: The 2020 MMWR for gonorrhea now recommends a higher dosage of ceftriaxone alone (rather than with azithromycin). The increased dosage of ceftriaxone will help prevent resistance patterns, thus no longer needing the addition of azithromycin.

We are pending a more comprehensive 2021 STI guideline by the CDC – please stay tuned for any updates.



CLINICAL PATHWAY:

THIS PATHWAY SERVES AS A GUIDE

Post-Exposure Prophylaxis (PEP):

Offer an anti-emetic 30-60 minutes prior to starting any PEP.

All patients:

- If within 72 hours of vaginal, anal, oral, or percutaneous contact with blood or semen that is possibly or definitely HIV infected: offer **HIV PEP** (see **HIV PEP Pathway**)
- Hepatitis B prophylaxis, if indicated (refer to **Appendix F – Hepatitis B Prophylaxis**)
- Tetanus prophylaxis, if indicated (refer to **Appendix G – Tetanus Prophylaxis**)

Pre-menarcheal female or male of any age:

- No prophylaxis recommended for GC, chlamydia or trichomonas.
- If active signs or symptoms of STI, call SCAN.

Post-menarcheal females:

- If urine HcG negative:
  - If exposure ≤72 hours: **Plan-B** (give in the ED)
  - If exposure >72 hours and ≤ 120 hours: **Ella** (outpatient Rx needed; Plan B not indicated)
  - Give anti-emetic 30 minutes prior.
- If alleged perpetrator ≥13 yo and possible genital contact within last 120 hours, offer PEP for GC, chlamydia and trichomonas:
  - GC:
    - If <150 kg: **ceftriaxone** IM 500 mg x1
    - If ≥150 kg: **ceftriaxone** IM 1 gram x1
    - *If PCN allergy*: Consult Infectious Disease
  - Chlamydia:
    - If >45 kg: **azithromycin** PO 1 g x1
    - If ≤45 kg: **azithromycin** PO 20 mg/kg (max 1 g) x1
    - *If azithromycin allergy and >45 kg*: doxycycline PO 100 mg BID x 7 days OR levofloxacin PO 500 mg daily x7 days
  - Trichomonas:
    - If >45 kg: **metronidazole** PO 2 g x1 [Contraindicated if pregnant in 1st trimester!]
    - If ≤45 kg: no prophylaxis recommended

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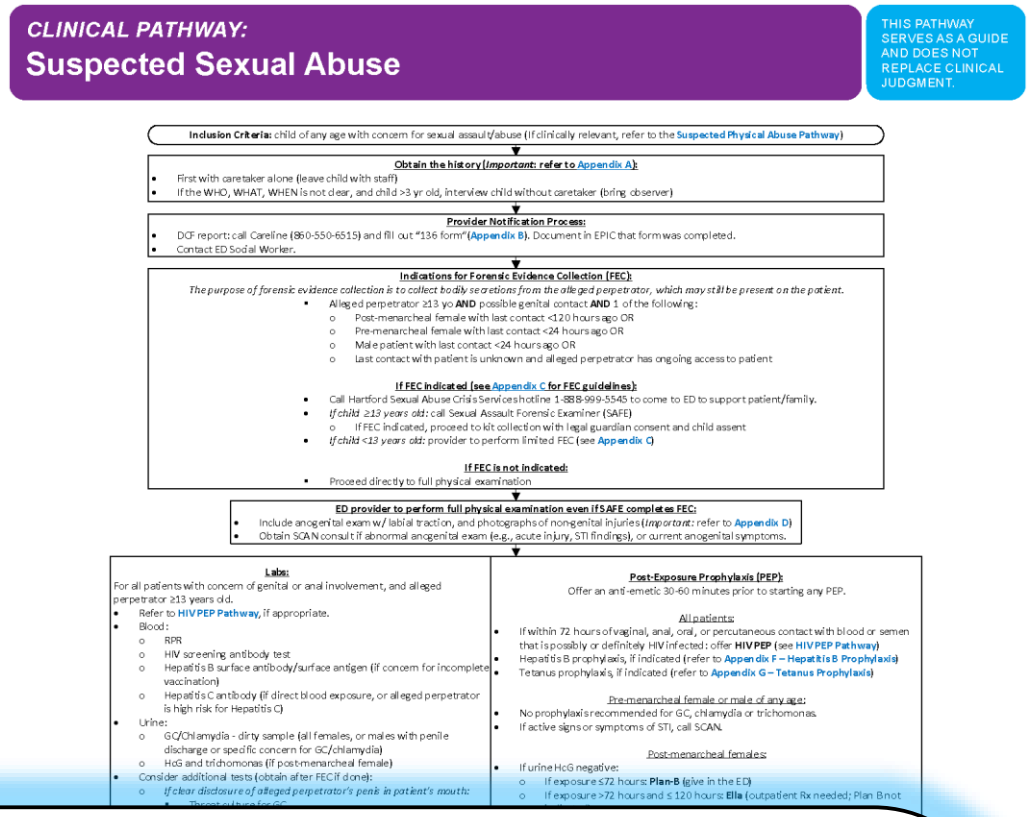
- Disposition guidelines are listed after work up and PEP is complete.
- If discharged, outpatient follow up, medication adherence, and continuing child's safety plan (including not questioning the child further) is important.

Note: ED providers can now place ambulatory referrals in Epic for SCAN (and ID, as appropriate)



CLINICAL PATHWAY:
Suspected Sexual Abuse

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Inclusion Criteria: child of any age with concern for sexual assault/abuse (if clinically relevant, refer to the Suspected Physical Abuse Pathway)

Obtain the history (*Important:* refer to Appendix A):
- First with caretaker alone (leave child with staff)
- If the WHO, WHAT, WHEN is not clear, and child >3 yr old, interview child without caretaker (bring observer)

Provider Notification Process:
- DCF report: call Careline (860-550-6515) and fill out "136 form" (Appendix B). Document in EPIC that form was completed.
- Contact ED Social Worker.

Indications for Forensic Evidence Collection (FEC):
The purpose of forensic evidence collection is to collect bodily secretions from the alleged perpetrator, which may still be present on the patient.
- Alleged perpetrator ≥13 yo **AND** possible genital contact **AND** 1 of the following:
  - Post-menarcheal female with last contact <120 hours ago OR
  - Pre-menarcheal female with last contact <24 hours ago OR
  - Male patient with last contact <24 hours ago OR
  - Last contact with patient is unknown and alleged perpetrator has ongoing access to patient

If FEC indicated (see Appendix C for FEC guidelines):
- Call Hartford Sexual Abuse Crisis Services hotline 1-888-999-5545 to come to ED to support patient/family.
- *If child ≥13 years old:* call Sexual Assault Forensic Examiner (SAFE)
  - If FEC indicated, proceed to kit collection with legal guardian consent and child assent
- *If child <13 years old:* provider to perform limited FEC (see Appendix C)

If FEC is not indicated:
- Proceed directly to full physical examination

ED provider to perform full physical examination even if SAFE completes FEC:
- Include anogenital exam w/ labial traction, and photographs of non-genital injuries (*Important:* refer to Appendix D)
- Obtain SCAN consult if abnormal anogenital exam (e.g., acute injury, STI findings), or current anogenital symptoms.

Labs:
For all patients with concern of genital or anal involvement, and alleged perpetrator ≥13 years old.
- Refer to HIV PEP Pathway, if appropriate.
- Blood:
  - RPR
  - HIV screening antibody test
  - Hepatitis B surface antibody/surface antigen (if concern for incomplete vaccination)
  - Hepatitis C antibody (if direct blood exposure, or alleged perpetrator is high risk for Hepatitis C)
- Urine:
  - GC/Chlamydia - dirty sample (all females, or males with penile discharge or specific concern for GC/chlamydia)
  - HcG and trichomonas (if post-menarcheal female)
- Consider additional tests (obtain after FEC if done):
  - *If clear disclosure of alleged perpetrator's penis in patient's mouth:*

Post-Exposure Prophylaxis (PEP):
Offer an anti-emetic 30-60 minutes prior to starting any PEP.

All patients:
- If within 72 hours of vaginal, anal, oral, or percutaneous contact with blood or semen that is possibly or definitely HIV infected: offer **HIV PEP** (see HIV PEP Pathway)
- Hepatitis B prophylaxis, if indicated (refer to Appendix F – Hepatitis B Prophylaxis)
- Tetanus prophylaxis, if indicated (refer to Appendix G – Tetanus Prophylaxis)

Pre-menarcheal female or male of any age:
- No prophylaxis recommended for GC, chlamydia or trichomonas.
- If active signs or symptoms of STI, call SCAN.

Post-menarcheal females:
- If urine HcG negative:
  - If exposure ≤72 hours: **Plan-B** (give in the ED)
  - If exposure >72 hours and ≤ 120 hours: **Ella** (outpatient Rx needed; Plan B not

Inpatient Admission Criteria:

Admit to Inpatient/Observation if mental health concerns or physical conditions requiring inpatient level of care. Place SCAN consult.

Discharge Criteria:

Stable with no injuries or mental health concerns requiring inpatient management; call/report made to DCF; chain of custody maintained on all forensic evidence; appropriate testing/treatment provided; safe discharge plan; place Epic order for urgent referral to SCAN, and provide number to SCAN 860-837-5890; if family declining SCAN referral – must be referred back to PCP; if on HIV PEP, place Epic referral to ID; if need vaccine completion – refer to PCP; ≥9 yrs old: refer to PCP to start HPV vaccine series)

Discharge Instructions:

Instruct family not to question child further; continue safety plan for child; follow up with appropriate appointments; begin medications as instructed; post-menarcheal females will need repeat pregnancy test every 2 weeks until menses

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Review of Key Points

- Make a DCF report for any concern of sex abuse or assault
- Obtain as much of the history from the caregiver when possible, and appropriate
- Perform a physical exam on all patients, including a genital exam, even if forensic evidence collection/exam was completed
- Consult SCAN for any abnormal GU findings
- Baseline labs should be obtained and all patients screened for HIV PEP need
- Consider Commercial Sexual Exploitation of Children (CSEC)
- Ensure safe and adequate follow up plan in place if patient is discharged

Diagnosis Codes to Utilize

- Suspected child sexual abuse T76.22XA
- Parental concern about child sexual abuse T74.22XA
- Parental concern about possible child sexual abuse T76.22XA
- Victim of human trafficking Z65.4

Quality Metrics

- Percentage of patients eligible for pathway with order set usage
- Percentage of patients who have a referral to the Suspected Child Abuse and Neglect (SCAN) team
- Percentage of patients age ≥ 12 years old with pregnancy testing performed
- Percentage of patients with DCF report completed
- Percentage of patients with completed and/or offered appropriate STI testing (HIV, syphilis, chlamydia, gonorrhea)
- Number of patients with forensic evidence collection completed
- Percentage of patients with forensic evidence collection completed who have a referral to the SCAN team

Pathway Contacts

- Nina Livingston, MD
  - Suspected Child Abuse and Neglect Team

References

- Adams JA et al. Interpretation of medical findings in suspected child sexual abuse: an update for 2018. *J Pediatr Adolesc Gynecol*. 2018 Jun;31(3):225-231.
- Adams JA, Kellogg ND, et al. Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused. *J Pediatr Adolesc Gynecol*. 2016 April;29(2):81-7.
- Allen B. Children with Sexual Behavior Problems: Clinical Characteristics and Relationship to Child Maltreatment. *Child Psychiatry Hum Dev.* 2017 Apr;48(2):189-199.
- Sexual Assault and Abuse and STDs. Centers for Disease Control and Prevention. 2015. https://www.cdc.gov/std/tg2015/sexual-assault.htm
- Dwyer K. Mandated Reporters of Child Abuse and Neglect. Office of Legislative Research. 2016. https://www.cga.ct.gov/2016/rpt/pdf/2016-R-0197.pdf
- Kellogg ND, et al. Genital Anatomy in Pregnant Adolescents: “normal” does not mean “nothing happened”. *Pediatrics.* 2004 Jan;113(1 Pt 1):e67-9.
- Kellogg ND, Committee on Child Abuse and Neglect, American Academy of Pediatrics. Clinical Report—the evaluation of sexual behaviors in children. *Pediatrics.* 2009 Sep;124(3):992-8.
- State of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault. 2017. https://portal.ct.gov/DCJ/19a-112a-Evidence-Commission/Technical-Guidelines/2018-Technical-Guidelines

Thank You!

About Connecticut Children's Clinical Pathways Program

The Clinical Pathways Program at Connecticut Children's aims to improve the quality of care our patients receive, across both ambulatory and acute care settings. We have implemented a standardized process for clinical pathway development and maintenance to ensure meaningful improvements to patient care as well as systematic continual improvement. Development of a clinical pathway includes a multidisciplinary team, which may include doctors, advanced practitioners, nurses, pharmacists, other specialists, and even patients/families. Each clinical pathway has a flow algorithm, an educational module for end-user education, associated order set(s) in the electronic medical record, and quality metrics that are evaluated regularly to measure the pathway's effectiveness. Additionally, clinical pathways are reviewed annually and updated to ensure alignment with the most up to date evidence. These pathways serve as a guide for providers and do not replace clinical judgment.