GUIDELINES FOR MEDICAL/HEALTHCARE FOR CHILD/ADOLESCENT/ADULT VICTIMS OF ACUTE SEXUAL ASSAULT

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Elements of medical/health care include:

Providing emotional support Trauma-informed care includes crisis intervention, the assessment of emotional state, current and required support systems and the assessment of the individual's safety, including risk to self. Safe discharge planning includes an individualized safety plan. If necessary, assist with finding shelter, and arrange follow up support. In children, support for the non-offending care giver is critical.

1. **Reviewing and documenting relevant medical history**
   Document any relevant medical conditions that may be exacerbated by the sexual assault or affect the medical treatment offered (i.e. chronic health conditions, current medications, allergies).

   For pediatric patients, the history taken should be for the purposes of medically assessing the patient/child, not as part of an official forensic statement. The details of the allegations should be obtained from the caregiver separately, CAS or police if possible.

2. **Completing a physical examination: non-genital and genital assessment**
   The expectation is that there is a head-to-toe exam completed in a sensitive and respectful manner.
   Clients may not tolerate a full head to toe exam, therefore priority should be given to focused areas based on the history obtained.
   Remember to screen for the potential of acquired brain injury, through either blunt force trauma or through strangulation. Screening for strangulation is important as clients often do not disclose this injury. Serious physical injuries need to be treated with the appropriate urgency (e.g., head or neck injuries., altered level of consciousness, continuous vaginal bleeding, or signs of intra-abdominal injury). Urgent medical needs always take priority over forensic evidence collection.
   - Tetanus prophylaxis should be offered as indicated (ie bite, laceration)
   - Recommend visit within 48 hours to provide medical/health follow-up care, and to document late developing bruises.

For pre-pubescent children- the likelihood of genital injury is minimal. If injuries or genital findings are present these findings should be reviewed with an expert.

A speculum examination should not be conducted in children/ adolescents unless clinically indicated such as pain/non-menstrual bleeding and should be done in conjunction with an expert in pediatric

genital examination. Clients who present for care following an act of sexual violence and/or intimate violence may require the following medical plan of care:

1. **Emergency Contraception Pills:** Emergency contraceptive pills can be provided up to 120 hours (five days) post-sexual assault for all patients at risk of pregnancy who are of reproductive age (includes prepubescent girls of Sexual Maturity Rating 3) and peri-menopausal women (less than one year without a period, trans male who may be taking testosterone)

Exemptions to providing emergency contraception include; tubal ligation, any highly effective hormonal method of birth control taken without interruption (IUD, patch, ring, BCP), and known pregnancy.

Recommended prophylaxis:

Intrauterine device:

The copper intra-uterine device (IUD) can be inserted into the uterus up to 7 days post sexual assault. While it is highly effective in preventing pregnancy, it may not be well tolerated by a person who was recently assaulted. This could be a consideration for clients who are experiencing intimate partner sexual violence or sex trafficking as repeated sexual assaults could occur.

Medications:

Option 1) Levonorgestrel (Plan B) is 95% effective for up to 24 hours, 85% effective for 25-48 hours, and 58% effective for 49-72 hours. Plan B can use used for up to 120 hours/5 days with a 50% effective rate at 73-96 hours (Dunn et al., 2012)

Dose: Levonorgestrel Tablet1.5 mg taken by mouth x 1 dose as soon as possible. .

Option 2) Ulipristal Acetate (Ella). Ella is MORE effective than levonorgestrel (Plan B) up to 5 days after unprotected intercourse (Black et al., 2004). See Appendix A for additional information about Ella.

Dose: The approved regimen for Ulipristal acetate is one oral dose of 30 mg up to 5 days after unprotected intercourse.

Discussion of Weight and BMI:

According to the Society of Obstetricians and Gynaecologists of Canada Clinical Practice Guidance, levonorgestrel-only emergency contraceptive pills may be less effective where body mass index (BMI) is greater than **25 kg/m^2** (> 165 lbs. or 75 kg) and ulipristal acetate for emergency contraception may be less effective where BMI is ≥ to **35 kg/m^2** (≥ 176 lbs.) (Black et al., 2004)**.**

However hormonal emergency contraception may still retain some effectiveness regardless of body mass index. If access and cost allow, ulipristal acetate should be the first choice offered where BMI is greater than 25 kg/m^2 and there is preference for hormonal emergency contraception.

Side Effects:

Levonorgestrel: Nausea (23%), Vomiting (5.6%), Dizziness (11.2%) Headache (17%), Abdominal pain (18%), fatigue (16.9%).

Ulipristal Acetate: Nausea (12%), Dizziness (5%), Headache (18%), Abdominal pain (12%), fatigue (6%), dysmenorrhea (9%).

The next menses might be early, on time or late (Black et al., 2004)**.**

Costs associated with ELLA and Plan B

ELLA = $28.32/tablet

Plan B [brand] = $17.00; [generic] = $8.60

Ella is not covered by the Ontario Drug Benefit or OHIP+ so if the hospital does not want to add it to the formulary, one option could be to prescribe to patients, who could then obtain it from a retail pharmacy

2. Management of Sexually Transmitted Infections

See the Canadian Public Health Agency website for the updated guidelines (April 2023):

www.phac-aspc.gc.ca/std-mts/sti-its/guide-lignesdir-eng.php

https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/gonorrhea/screening-diagnostic-testing.html

- Baseline testing in adults/adolescents should be considered and discussed as an option.
- STI testing should be conducted on all points of contact as reported in the sexual assault history i.e. pharyngeal, vaginal, rectal
- Baseline testing in prepubertal children is generally not required.

It is important that clinicians are aware of the various options for testing. To ensure accuracy of specimen collection guidelines for each type of specimen collection are available within the associated chapters of the Canadian Public Health Guidelines for Sexually Transmitted Infections.

Testing for Sexually Transmitted Infections following Sexual Assault:

1. **Patients with a penis:** urine NAAT for gonorrhea and chlamydia
2. **Patients with a vagina,**, **who consent to a speculum exam:**
   -NAAT swab for gonorrhea and chlamydia from the cervix (or vagina if cannot locate cervix)
   -culture swab from vagina for Gardnerella (BV) and trichomonas
   -Culture swab from cervix for gonorrhea (a culture for gonorrhea is recommended to be obtained in addition to the NAAT testing due to resistance forming in communities)

- Culture swab from cervix for chlamydia

3. Patients with a vagina, who do not consent to a speculum exam:

- NAAT Vaginal Swab or Urine NAAT for: Gonorrhea, Chlamydia, trichomonas. Either clinician or self-swab.
- Culture vaginal swab for Gardnerella (Bacterial Vaginosis). Either clinician or self-swab.
- Culture swab from vagina for chlamydia
- Culture swab from vagina for gonorrhea

Note: The **vaginal/cervical NAAT swab for gonorrhea and chlamydia** or **urine NAAT for gonorrhea and chlamydia** may become positive sooner than **the cervical cultures for gonorrhea and chlamydia,** and the patient should be treated on the basis of these positive NAAT results.

4. **Adolescents:** During the adolescent period patients display great variability in terms of degree of estrogenization, etc. Clinicians challenged with the medical and forensic examination of adolescents will need to consider the nature and risk of the assault, physical maturity, comfort of patient, etc, in deciding whether to do medical and forensic laboratory testing, A speculum exam is not indicated in adolescents. Proceed with vaginal swabs, either clinician conducted or self-swab.
5. **Prepubescent children:** Given the low prevalence of STI transmission in children, STI testing should be limited. A urine NAAT may be considered. In pre-verbal children, where there is a concern for SA, do not limit testing to sites in which penetration is described , consider all sites including rectal and pharyngeal (Kellogg, 2023). Vaginal swabs should only be collected if the child is displaying symptoms. A clinician with expertise in collecting vaginal swabs from children should be consulted, as this may necessitate the child to be sedated.

   For a prepubescent person with a vagina

   - Urine NAAT for Gonorrhea and Chlamydia
   - Vaginal swab NAAT for Gonorrhea, Chlamydia, trichomonas and culture (only conduct if symptomatic)

6.For patients requiring Rectal and Pharyngeal Testing: the following should be offered:

Consider rectal swab in females even if no anal-penile contact has been reported

Rectal NAAT & culture swab for gonorrhea and chlamydia

Pharyngeal NAAT & culture swab for gonorrhea and chlamydia

Gonorrhea and Chlamydia Treatment Management

As a network we encourage clients to make decisions for their own care within the context of their own unique definition of health, their assault history and medical history, and the information provided to them by the clinician offering them care at the SA/DV Treatment Centre. We promote client centered care that incorporates evidence-based guidelines specific to the client's developmental level and treatment specific plans for care.

The decision to take antibiotics at the time of presentation or to wait for results of testing before antibiotics are given rests with the client. The desire to preserve use of antibiotics for when there is a known positive contact or when there is a high clinical suspicion is an ideal situation but is often neither possible, nor preferable, when considered within the contact of the assault history and the client's level of fear. This is a personal decision to be made by the client after much discussion and consideration alongside the clinician offering care.

All clients should be offered follow up care. In some cases, a client may be better served in a more convenient location and efforts should be made to assist the client in that regard.

The following treatment guidelines are directly from the Canadian Public Health STI Guidelines found at: https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines.html

i) Adults and youth 9 years of age and older (including pregnant patients)

Gonorrhea: Ceftriaxone 250 mg intramuscularly (IM) with 0.9 ml of l% lidocaine PLUS Azithromycin 1 gram x 1 single dose OR cefixime 800 mg orally PLUS Azithromycin 1 gram x 1 single dose are both acceptable regimes.

While Ceftriaxone is considered first line, it is likely that our population may well choose the better tolerated Cefixime orally, to avoid injection.

Cephalosporins allergy or resistance or severe non-IgE-mediated reaction to penicillins, Azithromycin 2 g in a single oral dose PLUS Gentamicin 240 mg IM in two separate 3-mL injections of 40 mg/mL solution

NOTE: IGE mediated reaction is considered anaphylaxis. Stevens-Johnson syndrome and toxic epidermal necrolysis TEN) are considered non IGE mediated reactions and given the severity of these reactions clinicians should consider an alternative regimen,

Chlamydia: Azithromycin l gram orally x 1 dose OR Doxycycline l00 mg orally BID for 7 days. If allergy to macrolides and pregnant or breastfeeding, then amoxicillin 500 mg orally TID for 7 days

Note: 1Gram of Azithromycin covers both gonorrhea and chlamydia

ii) Children /Adolescents (Age 9-18)

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iii) Children/Adolescents (age 9 -18)

Chlamydia:

Azithromycin 12-15mg/kg (max. lg) orally once OR Doxycycline 5mg/kg/day in divided doses -max. 100 mg orally BID for 7 days. Consult with physician or pharmacist if contraindication or allergy to macrolides and pregnant or breastfeeding

iv) Children (<age 8)

Prophylactic treatment of sexually transmitted infections in prepubertal children is generally discouraged. If STI transmission is of concern the child should be brought back to a clinic for STI testing.

Sexually Transmitted Blood Borne Infections (STBBI's)

Hepatitis A

There is a risk of Hepatitis A transmission if there is oral-anal contact as Hepatitis A is transmitted via the fecal-oral route, which can occur from direct person-to-person contact or from contamination of the environment or objects. Transmission through infected blood or blood products has also been reported. Although not routinely given at the SA/DVTC, the Hepatitis A vaccine should be considered based on assault history and known risk factors.

Hepatitis B

HB is transmitted through percutaneous or mucosal contact with infectious biological fluids. Transmission of HB occurs through close contact with infectious bodily fluids, including through sharing of injection drug equipment (such as needles), sexual contact, and from mothers who are acute HB cases or carriers to their newborns.

For oral-genital or genital-anal contact:

- Draw blood for Hepatitis serology - HBSAg and HBSAb

- HBIG 0.06 ml/kg IM up to 2 weeks (best efficacy within 48 hours) post-assault PLUS 1st dose of vaccine (Engerix-B or Recombivax HB).
- Second and third dose of vaccine given at one and six months if serology negative (Note: if patient knows that they have been vaccinated and the serology is negative, a booster vaccination can be given)

https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-4-active-vaccines/page-7-hepatitis-b-vaccine.html

Hepatitis C

Transmission of hepatitis C occurs through blood-to-blood contact. Most new hepatitis C infections in Canada happen when people use contaminated equipment to prepare and inject drugs. Hepatitis C is not transmitted through casual contact such as kissing, hugging or sharing utensils.

In general, sexual transmission of hepatitis C is not common. The risk increases when certain factors are present, such as condomless anal sex, HIV, sexually transmitted infections, sex where blood is present, group sex and chemsex (using specific drugs to enhance or prolong sex). Thus, the risk of transmission may be higher among some groups of men who have sex with men (MSM).
https://www.catie.ca/hepatitis-c-an-in-depth-guide/intro-to-hepatitis-c

Bloodwork – Hepatitis C serology

https://www.canada.ca/en/public-health/services/diseases/hepatitis-c.html

Syphilis

The primary mode of transmission is by vaginal, anal and oral sexual contact
• Kissing (oral contact), sharing of needles and injection equipment, blood transfusion, accidental inoculation (e.g., needle stick injury) and solid organ transplantation have rarely been reported as routes of transmission.

https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/syphilis.html

HIV (Human Immunodeficiency Virus)

It is recommended that ALL patients be counselled about the possible risk of exposure to HIV from the assault. The option of taking HIV Post Exposure Prophylaxis (HIV PEP) should be discussed and offered. For clients at risk of HIV exposure who choose to accept HIV PEP, the current recommendations are as follows:

For adults and adolescents > 12 years old (pregnant or non-pregnant):

- **Tenofovir 300 mg/emtricitabine (Truvada) 200 mg** - l tablet once a day x 28 days
- **Dolutegravir 50 mg (Tivicay)** - l tablet once a day x 28 days

For adolescents <12 years old or unable to swallow tablets:

- **Zidovudine/lamivudine (Combivir)** - Dose according to weight
- **Dolutegravir (Tivicay)** - Dose according to weight

When considering HIV PEP for prepubertal children (<12 years old) consultation with a child abuse clinician, pharmacist or HIV expert should be obtained.

HIV PEP guidelines are available at www.(insert link) and the HIV PEP training and information can be accessed and downloaded from the Sexual Assault/Domestic Violence Treatment Centre's website: https://www.sadvtreatmentcentres.ca

HIV PrEP (Pre-exposure prophylaxis)

For patients that are at a high risk of ongoing or repeated HIV exposure (e.g. sex trafficking patients, intimate partner violence), consideration for HIV PrEP can be made. Given the need for prolonged care provision for HIV PrEP, we recommend referral to an appropriate HIV PrEP specialist (may be Infectious Disease, or Sexual Health Clinic, depending on your Centre).

HPV (Human Papillomavirus)

As of November 2023, our SA/DVTC's are not routinely providing the HPV vaccine to our clients. The Network of SA/DVTCs has submitted a request to Ontario Public Health for the provision of the HPV vaccine for our client population. These guidelines will be updated if we are approved to do so.

APPENDIX A

ULIPRISTAL (ELLA)

Ulipristral (Ella) was approved in Canada in 2015 for prevention of pregnancy if taken within 120 hours (5 days) of unprotected intercourse or suspected contraceptive failure.

MECHANISM OF ACTION:

Ella is a selective progesterone receptor modulator with antagonistic and partial agonistic effects.

It prevents the LH peak concentration that triggers ovulation and inhibits or delays ovulation by postponing follicular rupture

Ella has a direct inhibitory effect on follicular rupture that allows it to be effective a short time before ovulation

Ella works even when LH levels are rising vs levonorgestrel that works only before the LH rise. This may well account for its longer window of effectiveness.

Alterations to the endometrium may occur that impact implantation

The dose is one 30 mg tab.

IMPLICATIONS REGARDING OTHER FORMS OF CONTRACEPTION:

Keep in mind that if a female already has a LARC (long-acting reversible contraceptive in place e.g., IUD, Nexplanon, etc.) or is taking their oral contraceptive consistently, then an emergency contraceptive, is not needed as there is already protection. Emergency contraception is for females without a LARC or who is taking their oral contraceptive inconsistently. In this case, if a female wishes to start or continue a progestin containing hormonal contraception after taking ulipristal then they should delay start of the contraception for at least 5 days from ulipristal ingestion, as they may interfere with the action of the ulipristal.

- **IF STARTING AN ONGOING SHORT-ACTING HORMONAL CONTRACEPTIVE (e.g., ocp, patch, ring, etc.) FOLLOWING ULIPRISTAL:** Give Rx to start 5 days after ulipristal dose. Use back up method for those 5 days and an additional 14 days from contraception start
- **IF STARTING AN ONGOING LONG-ACTING REVERSIBLE CONTRACEPTIVE WITH PROGESTERONE FOLLOWING ULIPRISTAL (e.g. levonorgestrel IUD):** Insert levonorgestrel IUD 5 days after ulipristal ingestion. Use backup contraception for an additional 14 days from contraception start.

Reference: https://www.jogc.com/article/S1701-2163(16)30033-0/fulltext