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CME REVIEW ARTICLE

Care of the female adolescent rape victim

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TARGET AUDIENCE

This CME activity is intended for physicians, including pediatricians, pediatric emergency physicians, emergency physicians, family practitioners, and emergency department nurses, who provide care for the adolescent rape victim.

LEARNING OBJECTIVES

After completion of this article, the reader will

1. Be able to discuss the epidemiology of adolescent rape.
2. Be familiar with the acute evaluation of the adolescent rape victim.
3. Be familiar with collecting forensic evidence from the adolescent rape victim.
4. Be aware of the latest recommendations for prophylaxis of sexually transmitted diseases and pregnancy in the adolescent rape victim.

INTRODUCTION

Unfortunately, female adolescents are frequent victims of sexual assault and rape. The incidence of rape in the United States peaks among young women 16 to 19 years of age (1). The reported incidence of rape and sexual assault reflects a fraction of the actual frequency of this crime (1). The National Victim Center estimates that almost 700,000 women are raped each year, and that 61% of the rape victims are under the age of 18 (2). A survey of US high school students revealed that nearly 20% had one episode of forced sexual contact. However, only half of these students ever reported the assault to authorities (3). The reasons for not reporting these assaults include fear of public humiliation, perceived negative social stigma of rape, thinking that the event was a "matter of privacy," and fear

of "what happens next"—particularly the emergency department (ED) evaluation. A similar survey of female adolescents showed that 23% had experienced at least one episode of unwanted sexual contact (4). Nearly 25% of women sampled who were 17 to 19 years of age had reported unwanted sexual intercourse. The majority (84%) stated that they knew their assailant, and that many of these attacks (57%) occurred during a date (5). Male victims account for 5% of reported sexual assaults (6).

Any sexual act performed by one person on another without that person's consent defines a *sexual assault* (7). The use or threat of force, the inability of the victim to give appropriate consent, or both is an important component of this definition. Sexual assault in adolescents includes incest, acquaintance rape (ie, rape in which the assailant and the victim know one another), and stranger rape (rape in which the assailant and the victim do not know one another) (7). *Rape* has historically been defined under standard common law as "the unlawful carnal knowledge of a woman by a man, forcible and against her will, or without her consent" (8). A more current definition of rape is "a sexual assault in which the penis of an assailant is introduced into the victim's genitalia, either without consent or by threat of force or compulsion" (7). The age at which a person can grant consent for sexual intercourse varies with state law, which defines *statutory rape*. Thus, statutory rape has occurred even in "consensual intercourse" when one party is not of "legal age" according to the state law. As with other forms of child abuse, appropriate social service authorities need to be involved in all cases of suspected statutory rape.

Female adolescents are at high risk for becoming victims of acquaintance rape or "date rape." Studies have shown that the highest incidence of acquaintance rape occurred in grade 12 and during the freshman year of college (5, 9). Of the 25% of college women surveyed who reported having had unwanted sexual intercourse, 84% knew their assailant, 57% of the episodes occurred on dates, and 41% of the women stated that they were virgins at the time of the assault (5). Again, this is probably an underestimation of the true incidence of date rape.

There is an association between the high incidence of alcohol and drug abuse on college campuses and date rape (10). In addition, drug-facilitated sexual assault has received widespread media coverage in the past few years (11). At least 20 drugs have been documented as having been used in drug-facilitated sexual assaults and rapes (12). In a study of 1179 specimens collected from victims of sexual assault nationwide, 38% were positive for alcohols; 18% for tetrahydrocannabinol; 8% for benzodiazepines, including flunitrazepam (Rohypnol; Hoffman-LaRoche, Nutley,

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NJ), which is also known as the "date rape drug"; and 4% for gamma-hydroxybutyrate (12). These drugs are thought to be readily available at college campuses, bars, discos, and clubs. They produce disinhibition and relaxation of the voluntary muscles and cause victims to have retrograde amnesia for events that occur under the influence of the drugs (13–16). As with most sedatives, alcoholic beverages potentiate the effects.

Female adolescents who have been raped will present to the pediatric ED. The initial ED management of these patients includes documentation of pertinent history, careful physical examination and collection of forensic evidence, prompt recognition and treatment of physical injuries, psychosocial support with arrangements for follow-up counseling, prevention of venereal diseases, and prevention of pregnancy (17). A standardized approach to the initial management of the young woman who has been raped is warranted (Table 1). This type of approach provides a consistent process of evaluation, treatment, and collection of forensic evidence. Examples of standardized protocols are available (18, 19).

OBTAINING THE HISTORY

Adolescent victims of rape should be immediately identified in triage and quickly and quietly escorted to a private, secluded area. Their privacy should be respected, but they should not be left alone. In many states, physicians are required to report all cases of sexual assault to law enforcement agencies. Other state legal statutes may require parental notification of a minor's sexual assault. These statutes may override the confidentiality issues of the adolescent. If the adolescent is agreeable, parental notification should be encouraged.

After assurance that no severe physical injuries warrant immediate evaluation, a careful history should be obtained in a sensitive, nonjudgmental fashion and documented in a clear and concise manner. Pertinent historical information should include general demographic information; the name of the alleged perpetrator and relationship to the victim; the circumstances of the assault, such as location, particular sexual acts, physical violence, ejaculation, and physical and behavioral symptoms; any relevant medical history, such as menarche, last menstrual period, previous consensual sexual activity, possibility of preexisting pregnancy, previous history of sexually transmitted diseases (STDs); and the use of alcohol or drugs by the patient or the assailant before the assault (Table 2). Other components of the medical history, such as history of chronic illnesses, immunization history, current medications, and allergies, should not be overlooked.

Some adolescents may feel that specific questioning about the

TABLE 1

Physician's role in the care of the adolescent rape victim

Medical
Obtain and document medical history
Recognize and stabilize any emergent conditions
Evaluate and treat physical injuries
Obtain cultures
Offer STD prophylaxis
Offer postcoital contraception
Provide counseling
Arrange follow-up
Legal
Record events accurately
Document injuries
Collect forensic evidence
Fulfill reporting requirements according to state law
Notify proper authorities

Data from (21).

TABLE 2

Important history in the evaluation of the adolescent rape victim

Age and identifying information for both victim and alleged assailant
Date and time of assault and examination
Circumstance of assault
Details of the sexual contact
Types of physical abuse (use of restraints, weapons, drugs, alcohol)
Activities of the victim after the assault (changes of clothing, bathing, showering, urination, etc.)
Gynecologic history
Last menstrual period
Pregnancy history
Contraceptive use
Recent surgery or infections
Last voluntary sexual experience

Data from (76).

actual event is awkward and difficult and is a further invasion of their privacy. Initially, some individuals may be hesitant to answer truthfully, whereas others may welcome the chance to express their feelings and tell authorities exactly what has occurred to them. Questions should be specific, clear, and focused to avoid any ambiguity in responses.

All historical information should be recorded carefully in the medical record. Because the determination of rape is made in a court of law, the wording of the history should reflect the patient's report of the incident, and her exact words should be used as often as possible (20).

PHYSICAL EXAMINATION AND FORENSIC EVIDENCE COLLECTION

After ensuring the patient's comfort, the physician should perform a meticulous physical examination. Some health care professionals feel that informed consent should be obtained before the physical and forensic evaluation. In addition to fulfilling legal requirements, consent allows the victim a sense of control over the examination (21). As with all adolescent examinations, a female chaperone should be present. The adolescent patient should also be provided the opportunity to designate a family member or friend to remain in the room during the examination. The examiner should provide a succinct explanation to prepare the patient for the examination. All interactions with the victim should be in a deliberate, considerate manner with respect for the patient's modesty.

As with any other patient seen in the pediatric ED, any concerns with the patient's airway, breathing, or circulation should be immediately addressed. Five percent or more of rape victims have major nongenital injuries (22). In one study of adolescent victims, as many as 27% had extragenital sites of injury (23). An initial assessment for unstable vital signs, altered consciousness, peritoneal injury, and pain will alert the physician to severe lacerations, fractures, or internal injuries. As with any patient with trauma, treatment should follow appropriate resuscitation measures and diagnostic studies. One percent of sexual assault victims sustain nongenital injuries severe enough to require hospitalization (24). A recent study reported that of the severe nongenital injuries, 50% involved the face, head and neck; in 0.1% of assaulted women, the injuries are fatal (21). One review of fatal sexual assaults in adults reported the actual causes of death (in descending order of frequency) as mechanical asphyxiation, beating, lacerations, drowning, and gunshot wounds (25).

Genital trauma is possible even in rape victims who are asymptomatic on presentation to the pediatric ED (26). One study of adult rape victims showed that up to 63% of women who were sexually

assaulted had some type of genital injury compared with 11% of women who were examined after consensual intercourse. The most common types of genital injury reported were abrasions in the posterior fourchette, labia minora, hymen, and the fossa navicularis (27). Therefore, a careful pelvic examination should be performed to detect signs of trauma or injuries. If anal penetration is suspected or if signs of trauma exist, a rectal evaluation should be performed.

The patient's general appearance, clothing stains, and emotional status during the physical examination and the presence of any injuries must be clearly documented (24). The physician should identify edema, ecchymoses, abrasions, bite marks, and lacerations on the face, neck, torso, buttocks, and extremities. Presuming the presence of the assailant's saliva, the central portion of all bite marks should be swabbed with swabs moistened with sterile saline and placed in the appropriate envelope in the rape kit. Photographs of major injuries should be taken, and an outline drawing of the injuries on the body is helpful for documentation.

Although immediate medical care of the patient is of the highest priority, forensic evaluation fulfills important obligations to the victim, the criminal justice system, and society by attempting to document that a sexual assault has occurred and by aiding in the identification of the assailant (19). Necessary equipment for the collection of forensic specimens from the rape victim is contained in standard rape kits, which are available in most EDs.

A forensic evaluation should be performed within 72 hours of the sexual assault; however, the sooner the examination and specimen collection, the more likely that the forensic analysis will yield useful information with regard to markers that prove sexual assault or identify the assailant (19). As with any other evaluation, the examining physician has a role in determining which forensic sample is the most appropriate to collect on a case-by-case basis. The physician should try not subject the victim to unnecessary specimen collection, which may serve only to exacerbate the victim's feelings of being secondarily violated. Local law enforcement should be notified immediately upon disclosure that an assault occurred. This ensures rapid investigative response and a timely evaluation of the victim.

Familiarity with the rape kit is important to ensure that all specimens are collected properly and efficiently, thereby subjecting the victim to the minimal amount of discomfort. It is important to remember that this forensic evidence will not be available to the clinician to be used in the acute management of the patient. Generally, it has been taught that the patient's clothing should initially be examined with a Woods lamp to help in the detection of any seminal stains. However, a recent study concluded that the use of a Woods lamp is unreliable in the detection of semen. Furthermore, the correct identification of semen may be complicated by the presence of previously existing ointments and creams, some of which may be iatrogenically introduced (28). Clothing should be handled only by the victim and collected in a large bag after the patient disrobes over a clean sheet. Separate containers should be used for undergarments. A recent study in prepubescent victims of sexual abuse concluded that the victims' clothing yielded a significant amount of evidence and should be retained if at all possible (29). Conclusive data as to the evidentiary utility of the adolescent victim's clothes are lacking. A separate envelope and comb is provided for the collection of pubic and scalp hair. Loose hairs should be distinguished from the victim's own hair and placed in the appropriate envelope. Forensic analysis identifies hair types, distinguishes assailants' from victims' hair, and may prove useful in ruling-in a suspected individual (30). Perianal, oral, and vaginal swabs should be collected and placed in the appropriate sterile containers. To collect

saliva samples, filter paper and plastic tubes are recommended (21). If the victim scratched the attacker, the victim's nails should be examined closely. The victim's nails should be scraped with the cuticle stick provided in the rape kit to obtain material that could aid in identifying the assailant. Swabs for seminal stain collection should be moistened with saline for 60 seconds (21).

Examination of the genitourinary tract should first document the method of visualization (eg, direct, hand-held magnifying lens, speculum, or colposcope) and Tanner staging. It is important to use only saline for lubrication for insertion of the speculum because there is concern that other lubricants may alter evidence processing and interpretation (28). A plastic pipette and collection tube are provided for vaginal aspirates. These specimens should be evaluated for spermatozoa, seminal contents (including acid phosphatase, p30 protein and seminal vesicle-specific antigen), and ABO antigens by the forensic laboratory (21). A vaginal wash with small amounts of sterile saline may increase the likelihood of detection of this important evidence (31). The presence of motile sperm in vaginal secretions confirms sexual contact within the preceding few hours (30). The physician should complete the speculum examination and specimen collection before performing the bimanual examination. A Papanicolaou smear of the cervix may result in the detection of sperm several days after the assault (32). The collection of forensic samples is simplified by the use of clearly labeled envelopes, and the collection of evidence is made more efficient by familiarity with the rape kit.

Forensic analysis also involves the analysis of specimens to identify semen, blood, skin, and hair from the perpetrator. Seminal ABO grouping has been detected in the vagina up to 21 hours after intercourse and seminal DNA up to 70 hours after coitus (33). With current technology, the presence of semen may be confirmed by the finding of spermatozoa, which persist in motile form for up to 8 hours after intercourse in the vagina, for 2 to 3 days in the cervical mucus, and for an unknown amount of time in the rectum; non-motile sperm, which persist in the vagina and rectum for up to 24 hours and in the cervical mucus for up to 17 days; or seminal plasma glycoprotein p30, a protein specific to the prostate, which indicates ejaculation within 48 hours (34, 35). Seminal fluid is rapidly destroyed by salivary enzymes; therefore, it is more difficult to ascertain whether ejaculation occurred in the mouth (34). Seminal fluid on the skin or clothes has been reported to be present for up to several hours after the attack (21).

In approximately 80% of the population, soluble red-cell ABO antigen complexes (H antigen) are found in saliva, semen, and vaginal secretions (36, 37). Therefore, a sample of the victim's blood is drawn and placed in the appropriate preservative provided in the rape kit. After the victim's ABO status has been confirmed, foreign antigens are sought and cross-matched to the assailant (35). Newer forensic techniques, including DNA fingerprinting of blood, semen, skin, and hair, are becoming more widespread and sophisticated, and their results are admissible as evidence in many jurisdictions (38).

The routine use of colposcopy in the evaluation of adolescent rape victim remains controversial. Some physicians believe that colposcopy is not indicated in the evaluation of the adolescents who have been sexually assaulted. They argue that most pertinent physical examination findings can be seen without magnification or with a hand-held magnifying lens, and colposcopy is potentially an unnecessary intrusion (39). Other health care professionals support the routine use of colposcopy in the evaluation of the adolescent rape victim because of evidence that it aids in the detection of small abrasions, mucosal lacerations, and other subtle physical examination findings. Detection and documentation of these subtle injuries

may increase prosecution rates of assailants (3, 40). Toluidine blue, which stains DNA material, may be useful to better identify small abrasions and tears of the genitourinary mucosa with direct visualization (41).

A large number of women who have been raped do not have physical evidence of genitourinary trauma (42, 43). Studies of female rape victims have demonstrated that the incidence of genitourinary findings is approximately 30% (39, 44). It is impossible to tell whether a female adolescent has had previous sexual intercourse by examining the external genitalia. Secondary to the effects of estrogen, the adolescent hymen is very elastic and can permit penetration without tearing (45). In addition, genitourinary trauma can heal rapidly, so that small hymenal transections are not visible after a few days after the assault (45).

In many cities, sexual assault response teams have been developed to reduce the length of the waiting period for rape victims in the ED (46). The guiding principle behind these teams is to ensure that rape victims get timely, comprehensive, consistent medical treatment and evidentiary examinations, emotional support, and appropriate referral for further medical and psychological therapy. Many centers are based in hospitals, whereas others are contracted by police departments to provide 24-hour on-call service. Sexual assault nurse examiner (SANE) programs and sexual assault response teams (SART) are two examples of such programs (47).

Finally, forensic examination requires adherence to a "chain of custody." This requires documentation of all designated personnel handling the specimens and careful accounting of each step in the evidence process, from collection to the courtroom (19). All medical professionals obtaining specimens must identify themselves on the label or container seal; specimens are stored securely and release forms are signed, which document the transfer of the evidence to the police. The validity and admissibility of the forensic evidence in court is maintained by the use of meticulous records and documentation and by ensuring proper "chain of custody."

PSYCHOSOCIAL SUPPORT

Most adolescent victims of rape initially experience guilt, shame, and grief. They may tend to blame themselves for the assault, especially if drugs or alcohol were consumed or if the victim had voluntary sexual activity before the assault (21). Victims of acquaintance rape or date rape may experience a considerable violation of trust because of their previous social relationships with the assailants (7). Experts recommend that adolescents be encouraged to discuss their feelings, especially those of anger regarding the assault, because it is an important step in restoring self-esteem (21).

Rape victims may experience aspects of the Rape Trauma Survival Syndrome, a two-phased syndrome first described by Burgess and Holmstrom (48). Phase 1, the acute phase, is one of disorganization. The victim feels shock and disbelief regarding the rape. Victims may initially react in two ways: (1) in the expressed style, patients display anger, fear, and anxiety, and often cry during the interview; and (2) in the controlled style, the patient remains calm and composed and displays little outward emotion. Often, the controlled patient needs permission to express her emotions. This phase can last from 6 weeks to a few months. Physicians should anticipate either reaction and provide appropriate support and encouragement.

Phase 2, the reorganization phase, is a long-term process in which the victim develops certain coping mechanisms. Reorganization may include stages of outward adjustment, personal integra-

tion, and, finally, recovery. This phase may last a few months to a year, or indefinitely, depending on the patient.

More recent studies have documented a long-term psychological reaction to rape that has characteristics of posttraumatic stress disorder (49–51). This syndrome is characterized by the following four symptoms: (1) re-experiencing the traumatic event by intrusive thoughts, dreams, or flashbacks; (2) an avoidance of previously pleasurable activities; (3) an avoidance of the place or circumstance where the rape occurred; and (4) an increased state of psychomotor arousal leading to difficulties with sleep and memory (52). The patient should be made aware of the common psychological sequelae to rape, including sleep disturbances, changes in appetite, mood swings, and depression (53). Referral should be made for counseling through a rape crisis center, hospital social worker, or mental health facility. Ideally, patients should have psychological reevaluation approximately 1 to 2 weeks after the initial medical evaluation. All plans should be confirmed in writing, because patients often do not remember what is said to them during a crisis.

DETECTION AND TREATMENT OF SEXUALLY TRANSMITTED DISEASES

The risk for contracting an STD as a result of a sexual assault is influenced by regional variations in the prevalence of STDs (54). Prospective studies have estimated the risk of acquiring a STD as a result of sexual assault to be from 4.3% (if the victim denied any sexual activity in the previous 3 months) to 14.4% (with 85% of this group being sexually active in the previous 3 months) (55, 56). These studies have estimated the risk of acquiring certain STDs after a sexual assault to be 19.5% for bacterial vaginosis, 12.3% for *Trichomonas vaginalis*, 6 to 12% for *Neisseria gonorrhoeae*, and 4 to 17% for *Chlamydia trachomatis* (55, 56). In 1990, Jenny et al. (55) found no evidence of serologic or culture confirmation of the transmission of syphilis, herpes simplex virus, cytomegalovirus, or HIV in their study population of sexual assault victims. Other studies of post-assault transmission of STDs have shown a rate of 0.5 to 3% for syphilis and a rate of less than 1% for HIV (57, 58).

In 1994, the Working Group on HIV Testing, Counseling, and Prophylaxis After Sexual Assault estimated the risk of HIV transmission during sexual assault involving vaginal or anal penetration with exposure to ejaculate from a HIV-infected assailant to be approximately 2 per 1000 contacts (59). This is much lower than that of other STDs, including syphilis, gonorrhea, and hepatitis B. It is the researchers' opinion that immediate post-assault HIV testing and immediate prophylactic antiretroviral therapy is of limited usefulness, but periodic testing beginning within 6 weeks after the assault can be beneficial.

The overall probability of HIV transmission from an HIV-infected person during a single encounter depends on many factors, including type of sexual intercourse (eg, oral, vaginal, or anal); presence of oral, vaginal, or anal trauma; site of exposure to ejaculate; viral load in the ejaculate; and presence of an additional STD (60). Even though presently the Centers for Disease Control recommends antiretroviral agents in post-needlestick exposures, they fail to make a full recommendation regarding the appropriateness of postexposure antiretroviral therapy after exposure to HIV by sexual assault (60). More recent reports recommend that HIV prophylaxis should be offered to all victims of rape within 72 hours of their assault. The basis for this recommendation is that even though the absolute relative risk of HIV transmission in rape is not completely known (because the HIV status of the assailant is often not known), the rate of transmission must be higher than in unprotected consensual intercourse be-

cause of the traumatic nature of rape (61). The recommended treatment regimen (28 days) includes zidovudine, 300 mg twice daily or 200 mg three times daily, and lamivudine, 150 mg twice daily. They also conclude that further studies are needed to determine the risk of infection after sexual assault and document a benefit of prophylactic therapy. Presently, the American Academy of Pediatrics recommends that physicians “. . . consider offering prophylaxis for HIV depending on circumstances” (62). In situations that are of a particularly high risk (eg, the assailant is known to be HIV positive) the recommendation is “consultation with a experienced pediatric HIV professional and instituting antiretroviral therapy with zidovudine for 28 days” (62). Again, clinical trials of antiretroviral therapy after exposure to HIV by sexual assault in adolescent rape victims have not been performed.

Cultures for gonorrhea and chlamydia should be obtained from all sites of contact, such as the vagina or cervix, anus, and pharynx. Standard wet preparations and vaginal cultures are also indicated. Currently, culture methods are considered the legal gold standard and in some courts are the only test results that are permitted as evidence (16). Finally, diagnostic tests for syphilis are indicated, and appropriate treatment should be instituted after test results are known.

Certain prophylactic antibiotic therapy is generally recommended for the adolescent victim of sexual assault (63).

- For gonorrhea, ceftriaxone sodium (125 mg intramuscularly), cefixime (400 mg orally in a single dose), ciprofloxacin (500 mg orally in a single dose), or ofloxacin (400 mg in a single dose)
- For *C. trachomatis*, doxycycline (100 mg orally twice a day for 7 days) or azithromycin (1 g orally in a single dose)
- For trichomonas or bacterial vaginosis, metronidazole (2 g orally in a single dose)
- For hepatitis B virus, hepatitis B virus immunization at the time of initial examination if not fully immunized;
- For HIV, depends on the circumstance

If the patient is known to have been pregnant at the time of the assault, erythromycin or azithromycin may be substituted for the doxycycline, and metronidazole should be administered only after the first trimester. Finally, tetanus prophylaxis should be offered to unimmunized patients.

PREGNANCY PROPHYLAXIS

The overall risk for pregnancy as a result of sexual assault is as high as 5% (64). The risk of pregnancy is determined by establishing at what point in the victim's menstrual cycle the rape occurred. Unprotected intercourse 3 days before ovulation has been shown to result in pregnancy approximately 15% of the time, unprotected intercourse 1 to 2 days before ovulation results in pregnancy approximately 30% of the time, and unprotected intercourse on the day of ovulation results in pregnancy approximately 12% of the time (65). Documentation of a pregnancy test and the status of the last menstrual period at the time of medical evaluation should be routine. It should be explained to the patient that the pregnancy test is more for identifying pregnancy at the time of the assault and not pregnancy as a result of the assault. A recent study by Holmes et al. (64) documented that 90% of pregnancies that were a result of sexual assault were from assailants known to the victim. The researchers concluded that rates of pregnancies as a result of sexual assault are closely linked with rates of domestic and family violence.

In 1977, Yuzpe and Lancee (66) introduced a regimen for emergency contraception consisting of ethinyl estradiol and levonorgestrel to be taken within 72 hours of unprotected intercourse. A

second dose to be repeated 12 hours later is also recommended. Additional studies have confirmed that the administration of two oral contraceptive tablets within 72 hours of the assault and again 12 hours later will reduce the risk of pregnancy by 60 to 90% (67–69). At present, the American Academy of Pediatrics (63) recommends the following for emergency postcoital contraceptive in rape victims: two oral contraceptive tablets (each containing 50 µg of ethinyl estradiol) taken 12 hours apart or four oral contraceptive tablets (each containing 30 µg of ethinyl estradiol) taken twice 12 hours apart. The earlier the pills are taken after unprotected intercourse for emergency contraception, the more likely they are to be effective. Side effects of this high-dose hormone therapy include nausea and vomiting; thus, a short course of antiemetic therapy is indicated. Because the risk of post-assault pregnancy prophylaxis failure exists, the patient should be advised to have a second pregnancy test 2 to 3 weeks later to detect any such failures. Appropriate counseling as to the victim's options in dealing with failures is also indicated.

Compared to the method of postcoital contraception, the progestin-only method has recently been found to have a lower rate of side effects and an increased rate of pregnancy prevention (70). Until now, to achieve the desired dose of progestin, the patient needed to take twenty 0.75 mg levonorgestrel tablets. The Food and Drug Administration (FDA) has recently approved “Plan B,” which consists of two 0.75 mg levonorgestrel tablets (71). The current recommendation is to take one pill as soon as possible after the event (within 72 hours) and the other 12 hours later. Clinical trials in adolescent rape victims have yet to be performed.

Mifepristone (RU 486), commonly known as the “abortion pill,” will soon become another option in pregnancy prophylaxis in adolescent rape victims. The FDA has recently approved it as an abortifacient in the United States, and it can legally be prescribed off-label as a “morning after” pill. Currently, it is only available in a 200-mg concentration, which is a considerably higher dose than that required for emergency postcoital contraception according to published trials (72). Studies have shown mifepristone to be more effective than ethinyl estradiol as a postcoital contraceptive (57, 73). However, as of yet, there are no published guidelines as to its use as an emergency contraceptive in adolescent rape victims.

CONCLUSIONS

Rape is not uncommon in the adolescent patient. Each sexual assault has medical, social, and psychological implications for the victim and for society. Because the initial care a rape victim receives has been shown to influence her recovery (74), physicians should manage these patients with expertise and should use the latest recommendations in their care.

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