

2001 National Guidelines on the Management of Adult Victims of Sexual Assault

Clinical Effectiveness Group (Association for Genitourinary Medicine and the Medical Society for the Study of Venereal Diseases)

- These recommendations are limited to the management of victims of sexual assault within a Genitourinary clinic setting and include screening for and treatment of sexually transmitted infections (STIs) and addressing the need for psychological support. The documentation of a forensic examination and the collecting of specimens for evidential purposes is beyond the scope of these recommendations and should not be attempted by a Physician untrained in forensic medicine (1). The recommendations relate to female victims of sexual assault but the principles are similar in the management of male victims (2).
- These guidelines must be interpreted with a degree of flexibility dependent on the assessment of the emotional and physical state of the patient as well as the risk of infection. A pragmatic and compassionate approach is needed for a patient who may be desperately trying to regain control after the assault. The benefit to the patient, of any investigation must be weighed against the risk of exacerbating or prolonging the patient's distress.
- It is exceptional that the identification of a sexually transmitted infection (STI) assumes evidential importance, as prior acquisition would have to be excluded. Indeed the presentation of positive STI findings in court may hurt rather than help a victim's case (3). The finding of a STI may however, influence the level of criminal injuries compensation.
- Gonorrhoea, chlamydia and trichomoniasis are the infections most frequently identified in women who give a history of sexual assault (4, 5, 6). The peak age incidence of sexual assault is similar to that of many STIs, so their presence does not indicate acquisition as a result of the assault (6). The assailant is known to the victim in up to 60% of cases (7,8) and the anxieties of women assaulted by a previous sexual partner, particularly in regards to HIV, may be very different to those of a women assaulted by a stranger.

General Advice

Service Availability and staffing

- Need to maintain training in communication skills amongst all staff groups
- If identified as sexual assault victim- give suitable appointment-minimum waiting- if possible out of clinic hours.
- Experienced doctor - patient offered choice of female or male where possible

Reporting to the Police (IV, C) – see acknowledgements

- Ensure local Police aware of clinic service.
- Has patient reported to police –do they want to ?- Forensic examination useful up to 7 days post assault -must be prior to any medical examination.

- If a patient does not wish to report, the examination should be conducted and the findings documented with the thought in mind that occasionally the Doctor may be asked to produce a medical report at a later date.
- The orifices used in the assault, the timing of the assault, prior and subsequent consenting sexual intercourse, use of condoms by the assailant, and whether or not ejaculation had occurred should be documented.
- Signed consent is essential if any information is subsequently disclosed to the police. This should be with the understanding that the Court may order disclosure of all information divulged during the consultation.

History Taking

- Unrushed and sensitive manner.
- Orifices involved in the assault should be clarified- many women will not disclose forced oral or anal penetration without direct questioning .
- The sexual history both before and after the assault.
- Past medical history, gynaecological, menstrual and contraceptive history.

Examination (IV, C) see acknowledgements

Injuries requiring immediate attention should take precedence over any other examination.

- If the assault is recent, accurately document injuries found on genital inspection (diagrams may be useful). Petechial haemorrhages on the palate should be sought with a history of forced oral penetration. Anal examination including proctoscopy should be performed if there is a recent history of forced anal penetration, noting any trauma.
- Colposcopic examination and photography rarely provides any useful information outside a full forensic examination and may produce unnecessary distress.(4, 9)

Investigations (III, B)

A full STI screen at presentation is recommended as research suggests a significant incidence of pre-existing STI amongst women who allege rape and a smaller yet significant incidence of acquisition of STI resulting from the rape. There is also a high rate of default with second and subsequent appointments.(6,10)

Initial investigations should include the following-

- Cultures for *Neisseria gonorrhoea* and tests for *Chlamydia trachomatis* from any site of penetration or attempted penetration. Gram stained slides of urethral cervical and rectal specimens for microscopy for gonococci. (Although *C trachomatis* culture is the only test currently accepted in court, many laboratories no longer provide culture and the sensitivity of this test is suboptimal. Nucleic acid amplification tests (NAAT) offer greater sensitivity but their medico-legal use has not been established. It is advisable to take two endocervical swabs; one for NAAT and another for culture which should be placed immediately in chlamydia transport medium. The advantage of this duplication is that, in the event of a negative culture but positive first NAAT, the residual specimen can be used for a confirmatory test by a second NAAT which uses a different amplification target from the first. IV, C – A.J.Herring Ph.D. Head, PHLS Genitourinary Infections Reference Laboratory).
- Vaginal slides for microscopy for yeasts, Bacterial Vaginosis and *Trichomonas vaginalis* (TV). Ideally, if available, culture for TV.

- Blood for Syphilis serology and serum save . (Hepatitis B, HIV and, if indicated, Hepatitis C testing should be offered, as the patient may have a pre-existing risk for infection. If testing is not indicated, the sample should be saved to clarify the timing of any subsequent seroconversion).
- It is advisable that specimens are identified as having potential (albeit unlikely) medico-legal implications so the laboratory can complete a full range of confirmatory tests. The “Chain of Evidence” required for forensic specimens to be admissible as evidence (essentially- every handover of the specimen is signed, dated and timed) is often difficult to implement in a hospital laboratory situation. (IV, C) see acknowledgements

Treatment

- Antibiotic Prophylaxis

In situations where the patient may default, is unable to tolerate the distress of a repeat examination or requires an IUCD for emergency contraception then prophylactic treatment that would cover both chlamydia and gonorrhoea may be offered.

Recommended Regimens (IV, C - UK National Guidelines- clinical effectiveness group). -:

Ciprofloxacin 500mg stat, Doxycycline 100mg BD seven days
or Ciprofloxacin 500mg stat and Azithromycin 1g stat.

Pregnancy or Breastfeeding-

Amoxicillin 3g stat + probenecid 1g stat and Erythromycin 500mg BD 14 days

The efficacy of antibiotic regimes in preventing gonorrhoea or chlamydia infections after sexual assault has not been studied (11).

Many patients prefer prophylactic therapy to repeat examination (3). They should abstain from sexual intercourse until treatment has been completed.

- Hepatitis B vaccine (IV, C) see refs. below

Should be offered to all victims of sexual assault, however, it is not known for how long after the assault it may still be efficacious. As Hepatitis B has a long incubation period it may be of value up to 3 weeks after the event (12). It can be given as an accelerated course at 0,1 and 2 months or as a 0, 1 and 6 month regime (13) with the last dose coinciding with final serologic testing.

- HIV Prophylaxis (IV , C) see refs. below.

Post exposure prophylaxis (PEP) after sexual exposure is a controversial area and no widely accepted recommendations exist. (14)

A discussion about HIV infection should form part of the initial interview with the patient even if she/he has not raised the subject as this is often a concern. Although HIV seroconversion has followed sexual assault, the risk of HIV acquisition from heterosexual sexual assault in the UK is low.

An individual risk assessment will inform any decision about the offer of PEP. This involves several factors, including the background prevalence of HIV in the area where the assault occurred, any knowledge of the risk behaviour of the assailant, stranger rape versus known assailant, presence of other STI and the type of assault (e.g. forced anal penetration, being a greater risk than penile-vaginal rape by an HIV infected assailant). If PEP is to be given then it is recommended that this should be

started no later than 72 hours after a high risk exposure, the regime being in line with the post exposure prophylaxis guidelines for occupational exposure.(15) The patient needs to be aware of the unproven efficacy and potential toxicity of the treatment.

- Pregnancy prevention

If there is risk of pregnancy, post-coital oral contraception can be issued if within 72 hours of the assault and no risk of pre-existing pregnancy. (levonorgestrel 0.75mg 12hrly x 2 doses is preferred to the Yuzpe method)(16) (1a, A) IUCD insertion if used as post-coital contraception would be best covered by prophylactic antibiotics (as above) in these circumstances.

Counselling

- Post traumatic stress disorder is common following sexual assault, however there is no evidence that brief psychological debriefing reduces this. (17,18) The Health Adviser/nurse counsellor can discuss the patient's need for optional emotional support.
- Links with the local victim support organisation, rape crisis groups and a local Psychologist should be present to facilitate referral, if needed.
- As psychological sequelae may develop months or years later, communication with the GP to ensure continuity of care should be encouraged.

Sexual partners

Arrangements need to be made to see and treat the regular sexual partners of patients found to have a STI, if they may be infected. Patients and partners should abstain from sexual intercourse until treatment is completed.

Follow up (see table 1)

If prophylaxis was not given after the initial examination then a repeat STI screen at two weeks after the assault is advisable and should detect infections acquired at the time of the assault that were not detected on the initial examination.(IV,C-ref. 11) This is also an ideal time to review the emotional support needs of the patient. Serologic tests for syphilis, Hepatitis B and HIV should be offered (with counselling) at 12 weeks and, in high risk cases 24 weeks, as seroconversions of Hepatitis B and HIV have occasionally been documented outside the 12 week period (12,19) (IV,C). Although the risk from sexual assault is likely to be very low, Hepatitis C can be transmitted sexually and testing can be offered, particularly if the assailant is high risk (eg IVDU history) at 3 and 6 months.

Table 1

Timing of investigations

	presentation	2 weeks post assault	1 month post presentation	3 months post assault	6 months post assault
TESTS					
Chlamydia	+	<+>			
Gonorrhoea	+	<+>			
TV/BV	+	<+>			
Syphilis	+		(+)	+	
serum save	+				
HIV/HepB Abs	(+)			+	(+)
Hep C antibody	(+)			(+)	(+)
Treatment					
PCContraception	(+)				
antibiotic prophylaxis	(+)				
Hep B vaccine	+		+	+	
counsellor review	+	+	(+)	(+)	(+)

+ recommended timing

(+) if history or circumstances indicate

<+> if prophylaxis not given after first screen

Auditable Outcome Measures

- ◆ STI screen performed at initial visit -- target-90%
- ◆ Offer of emergency contraception if applicable -- target -90%
- ◆ Offer of emotional support made at initial visit.-- target -90%

Acknowledgements

I wish to thank the following for their valuable contributions to this Guideline:

Dr J Victoria Evans MB BS MRCGP DMJ DFFP Forensic Physician.

Dr Stephen P Robinson MB ChB MMJ, Senior Police Surgeon to Greater Manchester Police and Honorary Lecturer in Clinical Forensic Medicine at Manchester University.

Dr A.J.Herring Ph.D. Head, PHLS Genitourinary Infections Reference Laboratory, Bristol

Author and Centre

Helen Lacey Rochdale NHS trust

Membership of CEG

“Clinical Effectiveness Group: Chairman, Keith Radcliffe (MSSVD); Imtyaz Ahmed-Jushuf (AGUM); Mark FitzGerald (AGUM); Janet Wilson (Royal College of Physicians GU Medicine Committee); Jan Welch (MSSVD).”

Conflict of Interest none

Evidence Base

Medline 1980-September2000, search on exp “rape” as subject heading, limited to “adult” limited “english language” combined with exploded subject headings HIV infection,/sexually transmitted diseases, / patient care management.

Cochrane library Issue 4 2000, search -sexual and assault, Mesh exp “rape”

References

1. Rogers D. Physical Aspects of alleged sexual assaults
Med Sci Law 1996 36:2; 117-122
2. Hillman R. O'Mara N. Tomlinson D. Harris JRW. Adult male victims of sexual assault : an underdiagnosed condition. Int J STD AIDS 1991;2: 22-24
3. Ledray LE. Sexual Assault Nurse Clinician: an emerging area of nursing expertise.
AWHONNS Clinical Issues in Perinatal & Womens Health Nursing. 1993 ,4(2):180-90
4. Estreich S. Forster GE. Robinson A. Sexually transmitted diseases in rape victims
Genitourinary Medicine 1990;66:433-6
5. Lacey H B STDs & rape the experience of a sexual assault centre. Int J STD AIDS
1990;1:405-9
6. Jenny C. Hooton TM. Bowers A. et al. STDs in victims of rape. N Engl J Med 1990;322:
713-6
7. Muram D. Hostetler BR. Jones CE. Speck PM. Adolescent Victims of Sexual Assault
Journal of Adolescent Health 1995;17:372-375
8. Lamba H, Murphy SM. Sexual Assault and sexually transmitted infections: an updated
review. Int J STD AIDS 2000;11:487-491
9. Bowyer L. Dalton ME. Female Victims of Rape and their Genital Injuries
Br J Gynaecol 1997;104:617-620
10. Rambow B. Adkinson C. Frost TH. Peterson GF. Female Sexual Assault: Medical and
Legal Implications Ann Emerg Med 1992;21:727-731
11. Centre for Disease Control and Prevention. 1998 Guidelines for Treatment of Sexually
Transmitted Diseases .MMWR 1998;47:1-111
12. Crowe C, Foster GE, Dinsmore WW. Maw RD. A case of acute Hepatitis B occurring
four months after multiple rape. Int J STD AIDS 1996;7: 33-134
13. PHLS Hepatitis subcommittee CDR review 1992:2; R97-R101
14. Laurie J, Kennedy G, Rutherford G. Administration of antiretroviral post-exposure
prophylaxis (PEP) to decrease HIV infection in individuals exposed to HIV (Protocol for
Cochrane Review) in: The Cochrane Library, Issue 4, 2000. Oxford: Update Software
15. HIV Post-Exposure Prophylaxis- Guidance from the UK Chief Medical Officers' Expert
Advisory Group on AIDS : UK Health Departments July 2000

16. Cheng L, Gulmezoglu AM, Ezcurra E, Van Look PFA. Interventions for emergency contraception (Cochrane Review) in : The Cochrane Library, Issue 4, 2000.Oxford: Update Software

17. Foa EB. Trauma and Women: course, predictors and treatment. J Clin Psychiatry 1997;58 Suppl 9:25-8

18. Simon Wessely, Suzanna Rose, Jonathon Bisson, Brief psychological interventions (“debriefing”) for trauma related symptoms and the prevention of post traumatic stress disorder (Cochrane Review) in: The Cochrane Library, Issue 3, 2000.Oxford: Update Software

19. Centers for Disease Control and Prevention. Public Health Service guidelines for the management of health care worker exposures to HIV and recommendations for post exposure prophylaxis. MMWR 1998;47 (no RR-7):1-34