



Chapter 67 – Sexual Assault

Episode Overview

- 1) **What precautions should be taken prior to engaging in potential sexual abuse cases?**
- 2) **What information can be useful in determining the location and likelihood of injury in sexual assault?**
- 3) **What is the prevalence of mental illness in sexual assault patients? Which populations are found to have a higher proportion of mental illness? What effect does mental illness have on the severity of the attack?**
- 4) **What factors make genital injury more likely to be observed? Less likely?**
- 5) **What are the risks of STI's after sexual assault?**
- 6) **What are appropriate treatments for STI prophylaxis in cases of suspected sexual abuse/assault?**
- 7) **What resources exist to help medical providers and any victims of sexual abuse?**
- 8) **What differences should be considered with male victims of sexual assault?**

Thank-you to Dr. Sampsel* for her assistance with this episode!

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Rosen's in Perspective

- Definition from the CDC:
 - *“Sexual activity in which consent is not obtained or not freely given”*
- Does not require (but may involve) penetration, completion, or even non-physical contact (e.g. voyeurism)
- The past 30 years have seen the development of sexual assault response teams (SARTs) and sexual assault nurse examiners (SANEs) to respond to episodes of sexual assault and support the victims (SAVs).
- In the US, all SAVs must be offered forensic examination regardless of cooperation with police - this can cause issues regarding storage of evidence and chain of custody in cases of delayed cooperation.
- Allowing time for consideration of cooperation and supportive, high-quality health care increases cooperation with law-enforcement
- Epidemiology
 - SA is 10% of all assault-related visits to the ED by female patients
 - Leading cause of nonfatal violence-related injury for female patients and boys aged 1 to 9 years
 - 94% of victims reported are female
 - Estimates indicate 1 in 6 females and 1 in 33 males will be assaulted during their lifetime.
 - Many SAs are victimized by people they know (80%) - this is critical for safety planning
 - Between 40 and 80% of SAVs will experience non-genital trauma



- Adolescent SAVs tend to sustain anogenital injuries more frequently than adults

[1] What precautions should be taken prior to engaging in potential sexual abuse cases?

Remove patients from normal triage system - improve patient privacy, prevent degradation of evidence that can be caused by long waits in ED.

Two major aspects:

1. Victim consent
 - Box 67-1 details some consent issues in these cases
 - Acknowledge any mandatory reporting laws
 - Inform the patient about victim compensation funds
 - Explain and understand the examination, evidence collection, and user of photography
 - Understand that information gathered will be sent to law enforcement and **can (likely will) be obtained by defense counsel**
 - Anonymized data can be collected for educational and/or scientific reasons
 - Consent can be withdrawn at any time
 - There is no charge for the examination
2. Evidence gathering
 - Want to ensure a clear chain of custody - defer to your local SANE and/or forensic physician
 - Make sure to wear **powder-free gloves** to avoid contaminating evidence

[2] What information can be useful in determining the location and likelihood of injury in sexual assault?

Many factors involved (Table 67-1 and text). Typical location of injury for penetrative sexual assault with a penis is the posterior fourchette and body of the perineum. Other factors that can modify injury patterns:

- Type of sexual assault (phrase in terms understandable to the victim)
 - Include mechanism of assault and positions used
 - Female superior or rear-entry positions result in higher likelihood of anterior vaginal injury
- Sexual dysfunction history in suspect -> increased violence and frequency of anal penetration
- Use of foreign body -> injury pattern depends on object
- Victim assistance with insertion of penis -> less likelihood of injury
 - Note that this *should not* be construed as consent by the victim.
- History of victim's sexual experience -> higher likelihood of injury and hymenal trauma in victims with a lack of sexual experience
- Gravity/parity
- Mental health history -> increased violence of attack
- Substance use -> **may** increase likelihood of non-genital and anogenital trauma
- Method of controlling the victim -> weapons have distinct injury patterns.
Strangulation can result in airway injury.



- Be careful not to imply that the victim should have resisted/was complicit
- Multiple assailants -> increased violence of attack

[3] What is the prevalence of mental illness in sexual assault patients? Which populations are found to have a higher proportion of mental illness? What effect does mental illness have on the severity of the attack?

- Approximately 25% of SAVs will have a history of mental health issues.
- Having an MH history in the context of SA has been shown to increase the severity of the assault.
- Higher rates of MH difficulties are found in SAVs who are sex trade workers, women who have been incarcerated, homelessness, or who have a history of substance abuse.

[4] What factors make genital injury more likely to be observed? Less likely?

Box 67-10 in Rosens

Box 67-10 **Correlates of Genital Injury Found at Time of Sexual Assault Examination**

Decreases Findings
Increased time from assault to examination
History of menstrual bleeding at the time of assault

Increases Findings
Nongenital injury is associated with genital trauma
Penile penetration
Sexual inexperience and hymenal tearing
Postmenopausal
History of anal contact
History of stranger assault
History of sexual dysfunction in the perpetrator
Use of foreign object
Sexual assault victim (SAV) use of alcohol
SAV college graduate

More likely

- Concomitant non-genital trauma
- Penile penetration
- Sexual inexperience of victim
- Postmenopausal victim
- History anal contact
- History of stranger assault
- History of sexual dysfunction in the perpetrator
- Use of foreign object
- SAV use of alcohol
- SAV is college graduate



Less likely

- Increased time from assault to presentation at hospital
- History of menstrual bleeding at time of assault

[5] What are the risks of STI's after sexual assault?

- Any numbers given will vary with local prevalence of disease, and local data should be sought.
- Consider consulting the infectious disease service
- Table 67-5 gives a general overview of risk of STI following sexual assault
 - Gonorrhea: 6 - 18%
 - Chlamydia: 4 - 17%
 - Syphilis: 0.5 - 3%
 - HIV: <1%
 - Pregnancy: 2-4%, may be up to 50% in women age 19 to 26 with a mid-cycle exposure
- HIV transmission rate depends on many factors, including:
 - Type of contact (Anal > Vaginal, penetrated > penetrator)
 - Genital lesions, trauma, or anal trauma
 - Contraceptive methods
 - Menstruation
 - Perpetrator factors
 - Viral load
 - Presence of foreskin
 - ARV adherence
 - Multiple perpetrators

[6] What are appropriate treatments for STI prophylaxis in cases of suspected sexual abuse/assault?

- Rosen's recommends prophylactic treatment without testing (Box 67-12)
 - Ceftriaxone 250mg IM x1 or Cefixime 400mg PO x 1
 - Metronidazole 2g PO x1
 - Azithromycin 1g PO x1 or Doxycycline 100mg PO bid x7 days
- HIV PEP only in high risk encounters
 - NO PEP -Vaginal/anal penetration may have occurred but the source is known to be HIV negative or there is no reason to believe the source is HIV positive or in a high risk group (IDU or MSM) and the setting in which the assault took place is not considered high risk for HIV.
 - Unknown assailant or high risk prevalence or drug paraphernalia at scene = PEP
 - Risk of seroconversion is likely higher in sexual assault as compared to consensual intercourse due to increased genital trauma
- Consider emergency contraception up to 5 days after sexual assault if requested



[7] What resources exist to help medical providers and any victims of sexual abuse?

- Many emotional and somatic reactions can occur after sexual assault (Box 67-14), these should be reviewed with the patient
- Ensure appropriate follow-up/repeat examination to monitor healing
 - Also allows patient concerns, mood symptoms, physical issues, and somatic changes to be discussed and addressed
- In the United States, the Rape, Abuse, Incest National Network (RAINN) provides anonymous 24-hour counselling and support from trained volunteers
 - Familiarize yourself with local resources available
- In BC:
 - Note- FOR HEALTH CARE PEOPLE ONLY - NOT PATIENTS
 - Rapid Expert Advice and Consultation for HIV

The BC Centre for Excellence has created a 1-800 number for all family physicians, nurses, and pharmacists in British Columbia. Health care professionals can now call 604-681-5748 (Vancouver), or 1-800-665-7677 (Outside Vancouver) for timely and convenient clinical advice on HIV/AIDS treatment and management. REACH provides consultation services from infectious disease specialists, physicians, and/or pharmacists experienced in HIV management. This service is available 24 hours a day, 7 days a week.

[8] What differences should be considered with male victims of sexual assault?

- Much less common: 8% of SA outside of incarceration environments
- Likely lower reporting rates due to cultural/societal factors.
- Increased risk amongst:
 - Gay and bisexual men
 - Veterans
 - Inmates
 - Men from MH treatment centers
- Consider increased risk of exposure to HIV, Hep B and C due to increased rates of anal and oral sexual contact.
- Increased rates of non-genital trauma (up to 80%)