Emergency management of sexual violence victim


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EntryPoint

The role of an emergency physician /health worker in the ER

- Treatment of acute medical conditions and injuries.
- Preservation and collection of forensic evidence.
- Prophylaxis for pregnancy and sexually transmitted infection.
- Provision of psychosocial support services.

Stabilization of the patient

Possible injuries

- Internal injuries
- Blunt head injury
- Penetrating injuries
- Altered mental status
- Hemodynamic instability

Obtaining an Appropriate Medical & Sexual History

3 Rs Recognise
Record
Referral

Medical History

- Last Menstrual Period
- Recent (60 days) anal-genital injuries, surgeries, diagnostic procedures or medical treatments that may affect the interpretation of current physical findings
- Pertinent medical condition(s) that may affect the interpretation of physical findings (blood dyscrasias, etc.)
- Pre-existing physical injuries prior to the alleged assault

Pre/Post Assault History

- Other intercourse within the previous 5 days (anal, vaginal, or oral)
- Voluntary alcohol or drug use prior to the assault
- Voluntary alcohol or drug use between the time of the assault and presentation for examination

Assault Related History

- Loss of memory/consciousness
- Presence of non-genital or anal-genital injury
- Date/Time/Location of assault
- Alleged assailant(s)/Age/Gender/Ethnicity/Relationship to patient
- Methods utilized for assault: Weapons, physical blows, restraints, burns, strangulation, threat(s) of harm, involuntary ingestion of drugs

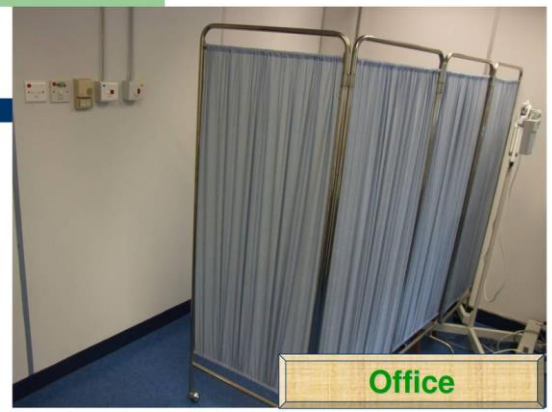
Assault Related Acts as Described by the Patient

- Vaginal Penetration
- Anal Penetration
- Oral copulation of genitals/anus
- Non-genital acts (licking, kissing, suction injury, biting)
- Ejaculation
- Use of foreign bodies
- Contraception or lubricant use

Post Assault Hygiene History

- Bodily functions: urination, defecation
- Utilization of genital or body wipes or douches
- Removal or insertion of tampons or diaphragms
- General hygiene activities: bathed/showered/washed; changed clothing; ate or drank; brushed teeth or gargled

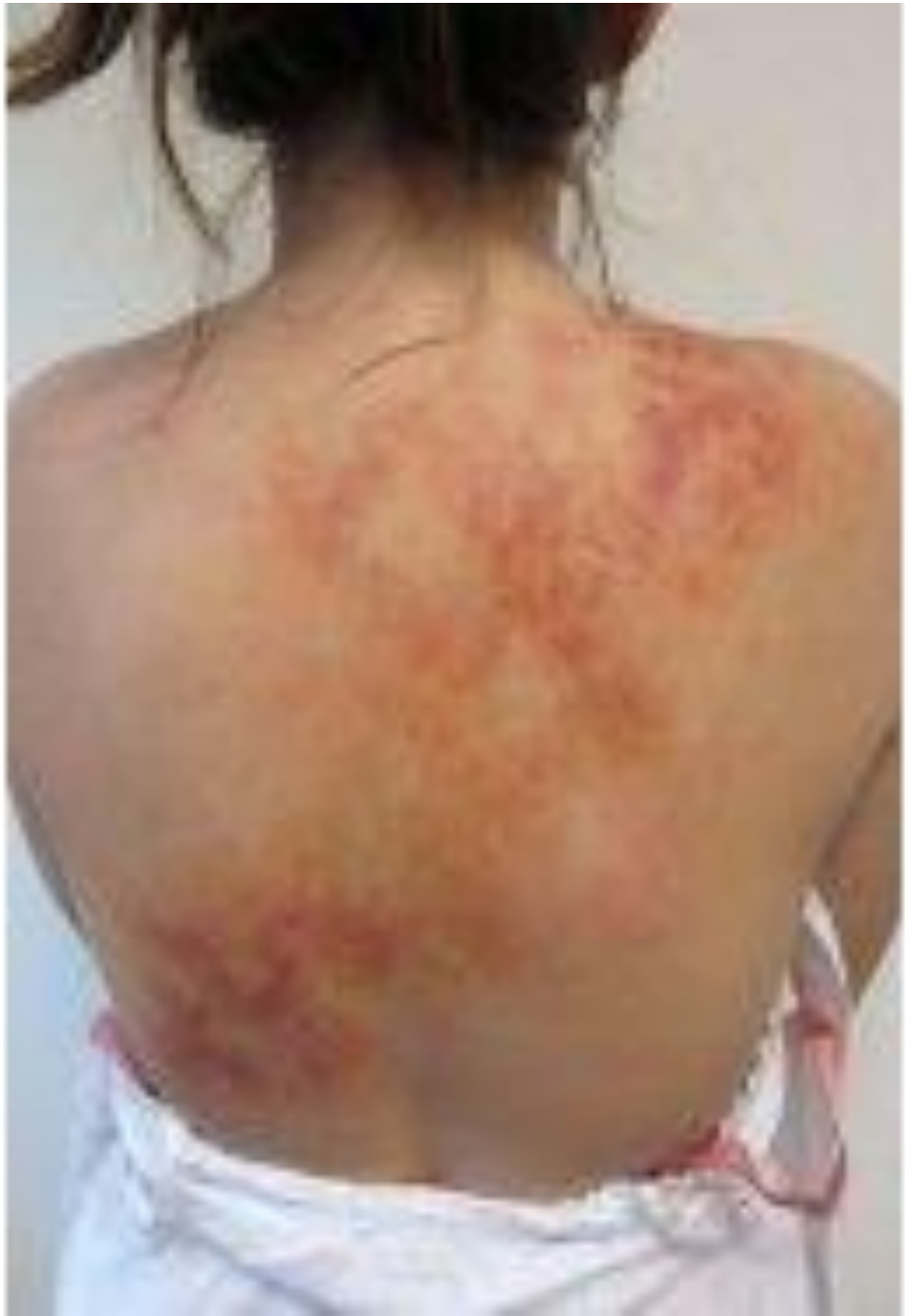
Physical exam



- Ensure the examination room is light, comfortable, clean, and private.
- The patient should consent to the examination
- Work with a chaperon
- Ideally should be done within 72 hours of assault.
- Should focus on identifying and documenting evidence of trauma.

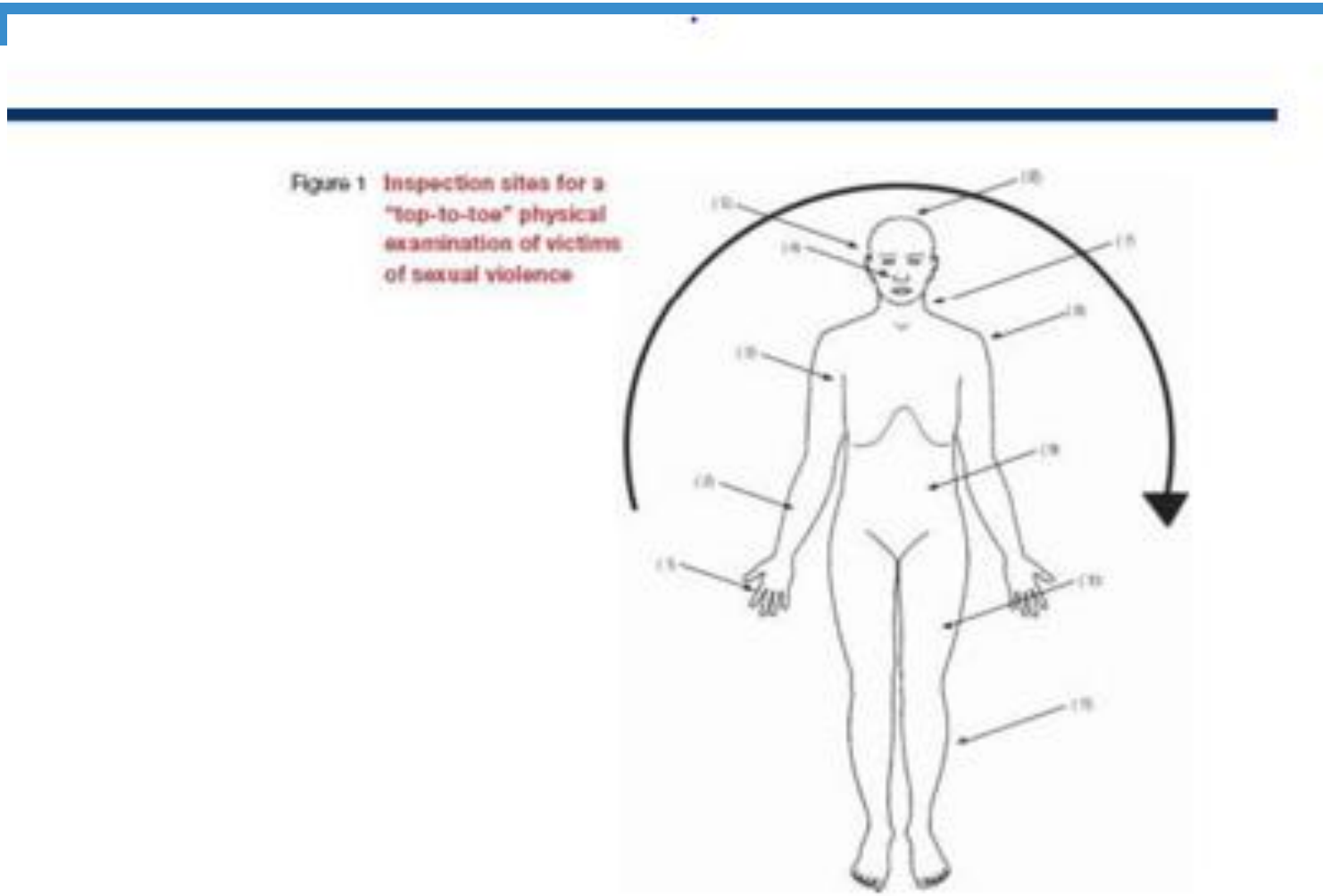
ACCRONOMY

T	Tears and tenderness
E	Ecchymosis
A	Abrasions
R	Redness
S	Swelling



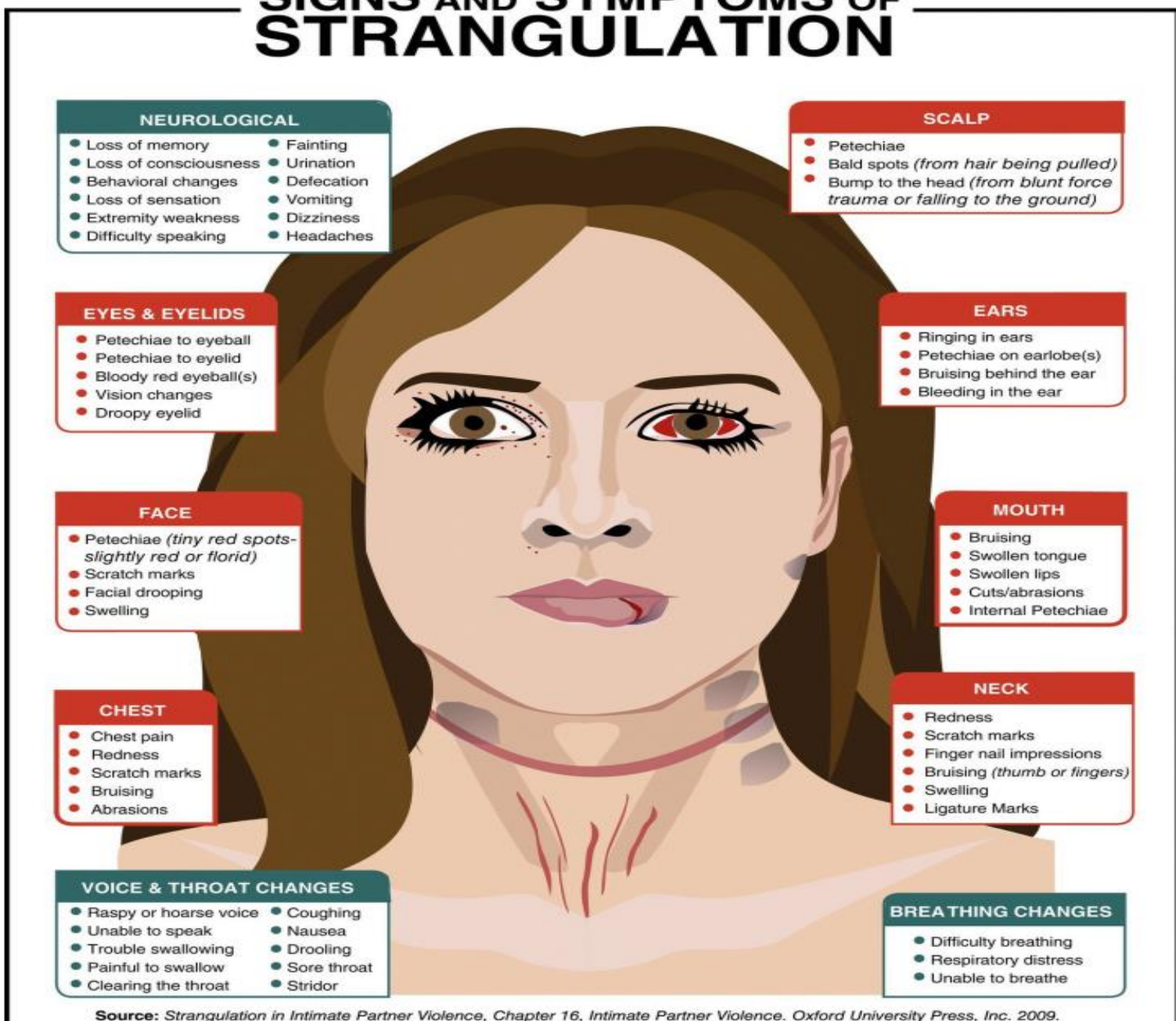
In the exam

A thorough head to toe exam should be done, looking out for any visible injuries, active bleeding and the areas of focus are as noted in the image below;



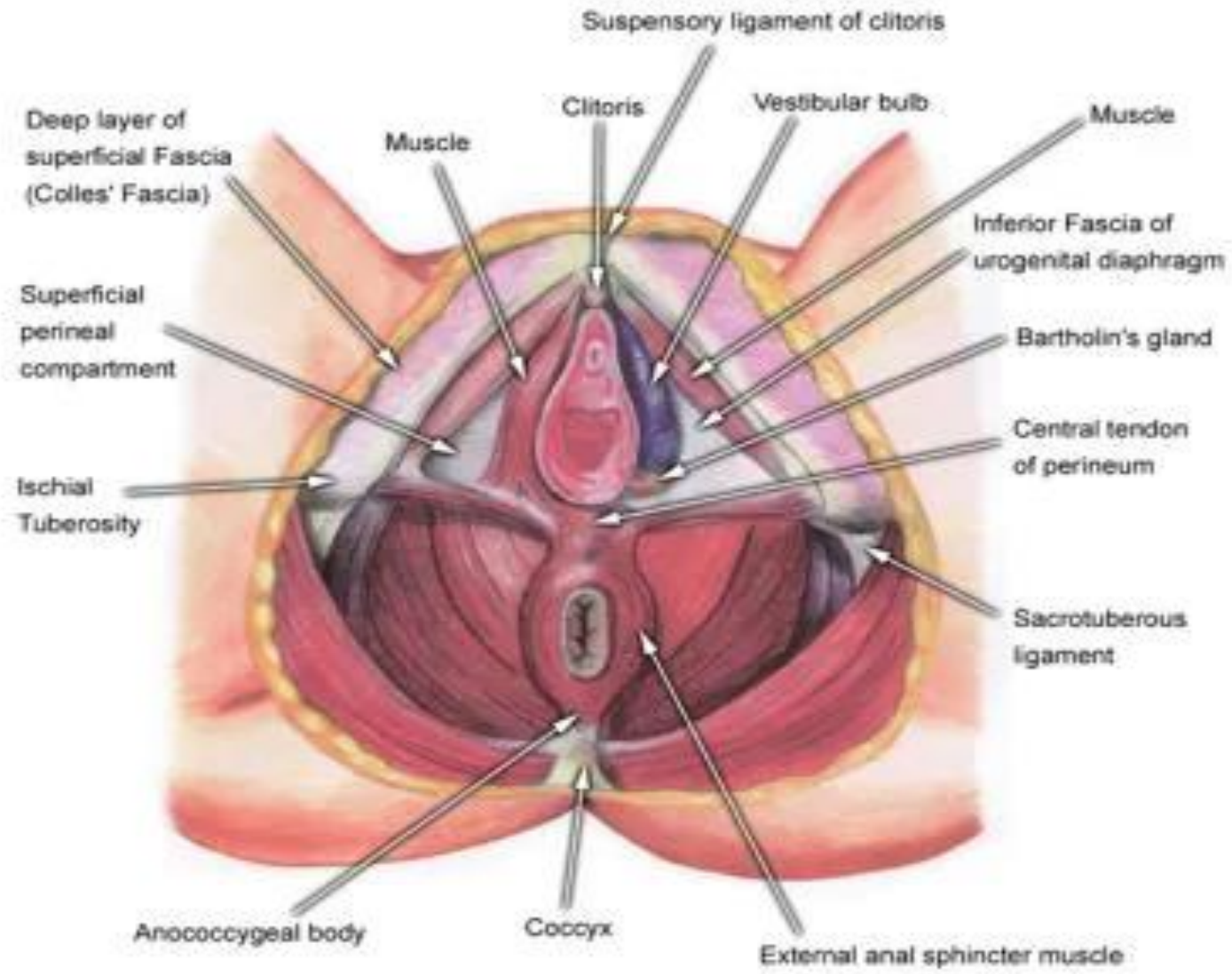
Presentation

In case the victim got strangulation, presentation can be summarized in the table.



Relevant anatomy

The genital tract should be assessed well for tears, bruises and active bleeding



Forensic evaluation

- Should be offered to individuals though not imposed or mandatory.
- Informed consent
- Ensure safe and good storage of samples. In some countries, evidence kits are used.

Samples collected

- Clothes
- Swabs from sites of contact
- Scalp and pubic hair
- Saliva
- Whole blood
- Fingernail scrapings

Work up

Laboratory

Test for presence of STIs(HIV, Hep B, Gonorrhoea, chlamydia, syphilis.

Pregnancy test

Wet preparations (may show motile sperm)

Toxicology screen

Imaging

It should be done based on hx and symptoms.

In younger girls, a skeletal survey may be important.

Management

- Perform initial resuscitation if not stable
- Manage any injuries
- Prophylaxis for HIV, Hep B, gonorrhoea, chlamydia
- Vaccination (HPV, Hep B and Tetanus)
- Emergency contraception
- Psycho-social support
- Follow up

Prophylaxis for STI

- Ceftriaxone 1g intramuscular in a single.

  PLUS
- Doxycycline 100 mg by mouth every 12 hours for 10 days **PLUS**
- Metronidazole 500 mg by mouth every 12 hours for 7 days

TABLE 293-5 Emergency Contraception

Drug	Dose	Comments
Levonorgestrel (Plan B®)	1.5 milligrams once *or* 0.75 milligram at 1 and 12 h	Prescribe antiemetics; less nausea than combined estrogen-progestin; available without prescription; 11–24/1000 estimated pregnancy risk
Combined estrogen-progestin[47] (Yuzpe®)	100 micrograms ethinyl estradiol *plus* 0.50 milligram levonorgestrel, at 1 and 12 h	Prescribe antiemetics; 29/1000 estimated pregnancy risk
Mifepristone	25–50 milligrams PO as a single dose	Menstrual delay most common side effect; 1–10/1000 estimated pregnancy risk
Ulipristal acetate (Ella®/Fibristal®)	30 milligrams PO as a single dose	Prescribe antiemetics; possibly fewer pregnancies than with levonorgestrel


32 mm / 1.26 in

Guidelines for HBV

- If assailant status unknown and survivor not previously vaccinated, give postexposure hepatitis B vaccination without HBIG, and inform survivor that subsequent doses must be given at 1–2 and 4–6 mo after first dose.[31]
- If the assailant is known to be HBsAg positive, unvaccinated survivors should receive hepatitis B vaccine and HBIG at the time of initial examination.
- For survivors previously vaccinated but who have not had postvaccination testing, give a single hepatitis B vaccine booster.
- HPV vaccination is recommended for female survivors age 9–26 y and male survivors age 9–21 y at the time of initial examination. Inform survivor that subsequent doses must be given at 1–2 mo and 6 mo after the first dose.[16]
- Empiric antibiotics for chlamydia, gonorrhea, and trichomoniasis (see Table 293-4).
- Tetanus prophylaxis if needed.
- Offer emergency contraception if the assault could result in pregnancy.[31]
- Baseline testing for syphilis, hepatitis C, and HIV.
- Obtain serum chemistries and liver function studies if HIV postexposure prophylaxis given.
- Provide first follow-up at 1 week.


HIV
POST
EXPOSURE
PROPHYLAXIS (PEP)
TRAINING SLIDES
pep

Patient disposition

- HOME VS ADMISSION

References

- TINTINALI TEXTBOOK OF EMERGENCY MEDICINE
- EM-RAP
- em-DOCs
- Lifeinfast lane