State of Oregon Medical Guidelines for Sexual Assault Evaluation

Adolescent (≥15 years)/Adult

Amendment to Section VII Diagnostic Test for Medical Treatment Page 17

VII	DIAGNOSTIC TESTS FOR MEDICAL TREATMENT
	The costs of the following tests will be covered by the Sexual Assault Victims' Emergency Fund when done as part of a sexual assault medical-forensic exam, following the restrictions as listed on the application. Patients should be informed that these tests will not detect very recent infection or pregnancy. Negative tests should not preclude the patient from receiving prophylactic medications. **Laws in all 50 states limit the evidentiary use of a survivor's previous sexual history, including evidence of previously acquired STIs, as part of an effort to undermine the credibility of the survivor's testimony. Evidentiary privilege against revealing any aspect of the examination or treatment also is enforced in most states.** **Decision to perform testing should be made on an individual basis** 1. STI testing, if done at time of acute assault, should be repeated at follow-up visit in 1 to 2 weeks if patient not completely treated during the initial examination and at again at 4 to 6 weeks, HIV should also be repeated at 3 to 6 months 2. Specimens for STI testing go to hospital/clinic lab NOT to crime lab 3. Inform patient that these tests are related to health issues and are not exclusively for forensic purposes
Pregnancy Test	**Obtain urine or serum pregnancy test on all patients at risk of pregnancy**
Toxicology Tests	**Hospital/clinic toxicology** 1. If toxicology and/or alcohol results are needed for patient care, stat hospital/clinic toxicology tests must be done
Vaginal Wet Mount	1. Not recommended to examine for sperm, due to lack of reproducibility and standardization 2. POC or wet mount with measurement of vaginal pH and KOH application for the whiff test from vaginal secretions may be performed for evidence of BV and candidiasis, especially if vaginal discharge, malodor, or itching is present

STI Tests for Gonorrhea and Chlamydia	1. Positive tests may indicate pre-existing infection. Highly sensitive tests such as Nucleic Acid Amplification Test (NAAT) may also indicate infection in assailant 2. For vaginal or penile infection • Urine NAAT test or vaginal or penile culture for gonorrhea and chlamydia 3. For anal infection • Culture for gonorrhea and chlamydia • NAAT test cannot be done 4. For pharyngeal infection • Culture for gonorrhea • Do not culture for chlamydia
STI Tests for Syphilis and Syphilis Serology	1. Syphilis baseline test may be offered 2. Serologic tests for syphilis should be repeated 6 and 12 weeks after the assault if initial test results were negative and these infections are likely to be present in the assailant 3. Prophylactic treatment for gonorrhea may prevent incubating syphilis from becoming clinical
HIV Testing	1. Baseline HIV testing is recommended prior to initiating HIV nPEP (see HIV nPEP guidelines), and should be considered on an individual basis, repeat at 6 weeks and 3 months 2. Patient must exhibit understanding that testing does not reflect acquisition of HIV from the assault, but related to possible exposure 2 weeks or more prior 3. If testing is done, arrangements must be made for follow-up contact to discuss results and provide counseling
Hepatitis B/C Serology	1. Indicated if patient is unsure of hepatitis B immune status 2. Hepatitis B/C serology is best done 3 months after last exposure 3. Baseline hepatitis B and hepatitis C testing recommended when initiating HIV nPEP

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VIII TREATMENT

Pregnancy Prevention

Emergency Contraception: Oregon Administrative Rules (OAR) 333-505-0120

1. A hospital providing care to individuals with female reproductive organs reporting a sexual assault shall:

(a) Promptly provide the victim with unbiased, medically and factually accurate written and oral information about emergency contraception;
(b) Promptly orally inform the victim of their option to be provided emergency contraception at the hospital; and
(c) If requested by the victim and not medically contraindicated, provide the victim of any child bearing age with emergency contraception immediately at the hospital, notwithstanding ORS 147.397 (defining the availability of the Sexual Assault Victims' Emergency Medical Response fund "SAVE Fund").
(d) For purposes of this rule, "emergency contraception" means the use of a drug or device that is approved by the United States Food and Drug Administration to prevent pregnancy after sexual intercourse

2. A hospital shall post a written notice, approved by the Division, to inform victims of their right to be provided emergency contraception at the hospital
3. Pursuant to ORS 109.640, anyone under the age of 18 has the right to consent to birth control information and services, including emergency contraception
4. A hospital shall document in writing that the information required to be given to a victim of sexual assault in section (1) of this rule, was provided. Failure to have such documentation may result in the issuance of a civil penalty

Since the effectiveness of emergency contraception is time dependent, if possible the patient should obtain medications prior to discharge or as soon as possible

Medications for patients who have a negative pregnancy test and are at risk for conception may be given as follows:

Levonorgestrel (Plan B) 1.5mg tab by mouth, take one tablet
Progestin-only pill
May not work well for patients with a BMI >25 and may not work at all in patients with a BMI >30
Works best to prevent pregnancy if given within 72 hours of assault, can work up to 5 days

-OR-

Ulipristal acetate (ella) 30mg by mouth, take one tablet
Most highly effective EC pill
May prevent pregnancy for up to 120 hours post assault
Works better for patients with a BMI >30 and may not work at all in patients with a BMI >35
Might make hormonal birth control methods less effective right after taking it, a backup birth control method should be used until next period starts

Do not administer different EC pills within 5 days of each other

	For patients with a BMI >35 Oral emergency contraceptives may not be effective in preventing pregnancy Patient should be given information on use of **Copper-T IUD (Paragard)** for EC • The most effective form of EC, reducing the risk of pregnancy by 99% when inserted within 5 days of assault • Works regardless of a person's weight • Not readily available in the emergency department • Patient will require bimanual examination, cervical inspection and STI screening by provider inserting IUD prior to use
STI Prophylaxis	**Every patient will be offered prophylactic treatment for sexually transmitted infections per CDC STI Treatment Guidelines, 2021**
Gonorrhea Prophylaxis	**Ceftriaxone** (Rocephin) 500 mg IM in a single dose For patients weighing ≥150 kg, 1g of ceftriaxone should be administered If ceftriaxone cannot be used (cephalosporin allergy) Azithromycin 2 g orally in a single dose **PLUS** Gentamicin 240 mg IM in a single dose
Chlamydia Prophylaxis	**Doxycycline** 100 mg orally twice a day for 7 days If concerns for compliance or pregnancy Azithromycin 1 g orally in a single dose Alternative regimen Amoxicillin 500 mg orally 3 times a day for 7 days
Bacterial Vaginosis/Trichomonas	**Metronidazole** (Flagyl) 500 mg orally twice a day for 7 days
Hepatitis B Vaccine and Immunoglobulin	If patient has been previously immunized for Hepatitis B but did not receive post vaccination testing, give a single vaccine booster dose If hepatitis status of assailant/s is unknown and patient has not been previously vaccinated, administer first Hepatitis B vaccine dose If assailant/s are known to be HBsAg-positive and patient has not been previously vaccinated, administer first Hepatitis B vaccine dose and also give HBIG Follow-up doses of Hepatitis vaccine are given 1-2 months after initial dose and 4-6 months after first dose
Tetanus Prophylaxis	**Offer when** 1. Skin wounds occurred during assault and 2. Patient not up to date for tetanus immunization (no immunization in past five years) 3. Patient signs consent for immunization

HPV Vaccine	Offer HPV vaccination for female and male survivors aged 9–26 years who have not been vaccinated or are incompletely vaccinated The vaccine should be administered to sexual assault survivors at the time of the initial examination, and follow-up doses should be administered at 1–2 months and 6 months after the first dose
Anti-Emetic Medications	Consider premedicating patients with antiemetics 15 to 30 minutes prior to administration of EC, STI, or HIV prophylaxis Offer food and water prior to medication administration when appropriate
HIV Prophylaxis **Assistance with PEP-related decisions can be obtained by calling the National Clinician's Post Exposure Prophylaxis Hotline (PEP Line) (telephone: 888-448-4911)**	**CDC Recommendations for Postexposure HIV Risk Assessment of Adolescents and Adults <72 Hours After Sexual Assault, 2021** Health care providers should do the following: Assess risk for HIV infection in the assailant, and test that person for HIV whenever possible If the survivor appears to be at risk for acquiring HIV from the assault, discuss PEP, including benefits and risks If the survivor chooses to start PEP, provide an initial course of 3–7 days of medication (i.e., a starter pack) with a plan in place for the individual to obtain remaining medications necessary to complete a 28-day course **OR** provide patient full course of medication or prescription for full course per facility protocol If the survivor chooses to start PEP provide counseling regarding medication assistance programs If PEP is started, obtain serum creatinine, AST, and alanine aminotransferase at baseline Perform an HIV antibody test at original assessment; repeat at 6 weeks and 3 months Counsel the survivor regarding ongoing risk for HIV acquisition and about HIV PrEP, and provide referrals to a PrEP provider See HIV Postexposure Prophylaxis (PEP) after Sexual Assault Guidelines and algorithm on the Attorney General's Sexual Assault Task Force website