The College of Emergency Medicine

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CLINICAL EFFECTIVENESS COMMITTEE

Management of Adult Patients who attend Emergency Departments after Sexual Assault and / or Rape

Summary of recommendations

1. Where possible and practical, victims of sexual assault and rape should be assessed in a Sexual Assault Referral Centre. Level 5 evidence Strong recommendation.

2. Any forensic examination should only be performed by a clinician with suitable specialist training in an appropriate environment. Level 5 evidence Strong recommendation.

3. Person identifiable information about sexual assaults and rapes should not normally be shared without consent, except in exceptional circumstances. Level 5 evidence Strong recommendation.

4. Emergency contraception should be available to victims attending the emergency department. Level 5 evidence Strong recommendation.

5. There is no requirement for emergency physicians to take pre-transfusion blood samples for the police. Level 5 evidence Strong recommendation.

6. Post exposure prophylaxis for sexually transmitted infections should be available to victims attending the emergency department. Level 2 evidence Strong recommendation.

Scope

This guideline has been developed to assist Fellows and Members of the College of Emergency Medicine caring for adult patients who have suffered rape and sexual assault.

Reason for development

To improve patient care.

Introduction

Definitions

In England and Wales, under the Sexual Offences Act 2003 the definition of rape is the non-consensual penetration of vagina, mouth or anus by a penis.[1,2] Sexual assault by penetration is the non-consensual, intentional insertion of an object other than the penis into the vagina or anus. The Act also treats any sexual intercourse with a child under the age of 13 as rape and defines the age of consent as 16.

Epidemiology

Only a minority of sexual assaults are reported to the police. Sexual offences are common,[3,4] but infrequently present to emergency departments, though accurate data is lacking. While the majority of assaults are against women of child bearing age, the elderly and men can be victims too. The majority of assailants are known to the victims and a large numbers of cases are associated with drinking alcohol.[5,6] Sexual assault may not be disclosed initially and the treating clinician should be suspicious when there is domestic violence and in patients requesting for emergency contraception.

Consequences of sexual assault

Rape may result in physical injuries, sexually transmitted infections including HIV, unwanted pregnancy and psychological symptoms, which may culminate in post-traumatic stress disorder and affect immediate family or partners. These can range from sleeping difficulties, poor appetite, flashbacks, feelings of numbness, anger, shame and denial, avoidance behaviour, depression, suicidality and relationship and sexual difficulties.

Role of the Emergency Physician

The responsibilities of an Emergency Physician are to; initially treat any injuries, manage medical needs, preserve and record any evidence and manage the psychological problems. The Guideline group emphasised that victims of sexual assault and rape should be treated with compassion and empathy.

Assessment

A Sexual Assault Referral Centre (SARC) is a one-stop location where victims of sexual assault can receive medical care, psychological counselling, legal advice and other support, all in one place from professionally trained staff. They bring together all of the different legal and medical agencies and departments in one place, which helps both the victims and those investigating the crimes. [7,8] Victims can choose to be dealt with anonymously if they do not wish any involvement form the police. For the nearest SARC please look at the link. (This does not have locations for Scotland or Northern Ireland.)
http://maps.google.com/maps/ms?ie=UTF8&hl=en&msa=0&msid=110494870022180976736.000493bef414397b01210&z=6

What should occur in an ED

Emergency Department staff should direct patients onto a SARC, though the decision to attend a SARC is the victims. If a victim is unwilling to attend a SARC, Emergency Department staff should respect that decision.

Patients who present to the Emergency Department should be assessed for physical injuries that may require treatment. Treatment of associated immediate life threatening injuries takes priority over forensic examination. If there are none, then patients should be referred for further assessment in a SARC. Referring a patient to a SARC does not necessarily involve the police. If the victim is unwilling or unable to attend the SARC, appropriate medical care should be offered. Assessment should be conducted in a non-judgemental, confidential and supportive manner.

Only a relevant history and all injuries should be recorded. Do not attempt any form of pelvic examination as this may disrupt any forensic samples. There are few occasions when the collection of evidence should be considered in the Emergency Department. The Home Office and ACPO (Association of Chief Police Officers) have recommended that Emergency departments have Early Evidence Kits available. [9] These should be only used when the clinicians have appropriate training, skill maintenance, and there is an agreed protocol and environment for maintaining the chain of evidence.

Clothing

When cutting off or removing clothing during a resuscitation procedure hospital staff should avoid cutting or damaging evidence bearing areas such as stab holes, blood stains and bullet holes.

Where the victim of a serious assault and/or sexual abuse has to be undressed - if conscious he or she should stand on a piece of clean brown paper whilst stripping and each garment packed up separately into a brown paper bag. If unconscious the paper couch liner should be retained also. Wet or blood-stained garments should not be put into a plastic bag as this will lead to decomposition rendering forensic analysis very difficult. The responsibility to collect evidence and maintain the chain of evidence resides with the police and a forensic medical examiner

Pre-transfusion blood sample

There is no requirement for pre-transfusion blood samples, unless this is performed as part of an assessment for exposure to blood borne viruses. If the police request a pre-transfusion blood sample, this service should be provided by a suitably trained doctor, usually a forensic medical examiner, who can quality assure the chain of evidence. [9]

Role of the Emergency Physician

The emergency physician must appreciate that their response to disclosure may have an important impact on their patient. The emergency physician should be sensitive and sympathetic. The absence of injuries does not exclude sexual assault, and the emergency physician should not conclude that absent injuries means that the allegations are false. Particular effort should be made to take accurate and contemporaneous notes.

Any forensic medical examination should only be performed by a clinician with suitable specialist training, ideally in a forensically secure environment to avoid DNA contamination. The medical assessment should ideally be performed by the most senior or appropriately trained doctor in the emergency department. Patients should be offered a choice of gender of the doctor where possible.

1. Look everywhere for bruising, abrasions, and lacerations and any patterns such as fingertip marks.
2. Look and treat for any bite marks. Advise the police of their presence as they may consider calling for a forensic odontologist.
3. Document carefully the presence and/or absence of injuries. You may be asked to produce a statement at a later date or attend court.
4. Consider the possibility of pregnancy. Emergency contraception should be offered to the victim.
5. Consider the possibility of exposure to sexually transmitted infections, a referral to local resources, screening for and prophylaxis against sexually transmitted infections, including HIV and as facilitating a follow-up for screening for sexually transmitted infections, counselling and psychology.
6. Victims may need further referral to Social Services, Victim Support, a Community Safety Unit or other organizations which can offer them support after the assault.
7. Any concerns about child welfare should lead to the activation of local safeguarding procedures.

Information sharing with outside agencies

Emergency physicians should assume that clinical information is confidential. Patients should be offered police involvement, but any decision not to involve the police should be respected. In exceptional circumstances, information can be shared with the police and statutory agencies such as social services. These circumstances include:

1. Where the victim is a child. Any sexual assault of a child should trigger local safeguarding procedures.
2. Where there are concerns about the welfare of children of the victim.
3. Where the victim lacks capacity and is unlikely to regain capacity.
4. Where guns or knives have been used by the perpetrator.

The decision to share information with outside agencies should be taken by the supervising Consultant and ideally discussed with another Consultant. Clear documentation of a decision to share information should be documented in the patient's case notes and this should be communicated to the patient, where practical.

Exposure to blood borne viruses

Assessing exposure to infections is often difficult and the donor is rarely available or willing to provide samples for testing. Where there is reasonable doubt that the patient has been potentially exposed to sexually transmitted infections, prophylaxis should be provided. [9] Expert advice should be sought from the relevant on-call service. This varies between organisations, but is usually from the genito-urinary medicine or infectious diseases services .

Hepatitis B: if the perpetrator is not known to Hepatitis B negative, then accelerated Hepatitis B vaccination should be considered. This usually involves a dose of Hepatitis B vaccine at the time of presentation and two further doses from the patient's General Practitioner at one and two months after the exposure.. Hepatitis B Immunoglobulin should be provided at the time of presentation and provides passive immunisation for up to 7 days after an exposure.

HIV: The decision to offer Post Exposure Prophylaxis after Sexual Exposure(PEPSE) is not always straightforward. PEPSE should be considered where; the assailant is known to be HIV positive, has risk factors, anal rape, multiple assailants or there is bleeding.

PEPSE may be effective at reducing HIV transmission if it is administered within 72 hours, but is more effective when administered earlier. Emergency departments should have access to PEPSE. Patients who receive PEPSE should be followed up by an appropriate service, usually the genito-urinary medicine service who will decide whether to continue PEPSE and will carry out baseline bloods including an HIV test.

Exposure to bacterial infections

Transmission of sexually transmitted infections is more likely where there are multiple assailants, biting, defloration, wounds, or anal intercourse. Transmission is also likely when the assailant is a man who has sex with men, or injects illegal drugs. Genito-urinary medicine follow-up should be offered as the initial assessment may be too early for most sexually transmitted infections to be evident

Prophylactic antibiotics should be offered, often single dose. Local protocols vary but a suggestion is shown below.

Cefixime 400mg and Azithromycin 1g once.

For pregnant or breastfeeding women, amoxillin 3g with probenicid 1g and erythromycin 500mg for seven days is an alternative, but these cases should be discussed with the relevant on-call specialty, either infectious diseases or genitor-urinary medicine.

Psychosocial care

The victim often knows the perpetrator which may lead to psychosocial problems. Emergency physicians should be able to identify and support patients who develop post-traumatic stress disorder and depression by referring them to SARCs or the patient's GP. Appropriate written information about relevant services should be available in the Emergency Department.

Useful organisations and sources of information

Rape Crisis: http://www.rapecrisis.org.uk/

Victim Support: http://www.victimsupport.org.uk/

Women's Aid: http://www.womensaid.org.uk/?gclid=CJ7gycm2qo8CFQE_MAodJy1VJg

DirectGov: Advice for victims:
http://www.direct.gov.uk/en/YoungPeople/CrimeAndJustice/TypesOfCrime/DG_10027698

The Havens: http://www.thehavens.co.uk/

SARCs: http://www.homeoffice.gov.uk/crime-victims/reducing-crime/sexual-offences/sexual-assault-referral-centres/

Care and evidence: http://www.careandevidence.org/

FFLM: Caring for rape and sexual assault victims.
http://fflm.ac.uk/upload/documents/1176896556.pdf

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Review

Within three years or sooner if important information becomes available.

Disclaimers

The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Research Recommendations

None identified.

Audit standards

There should be a documentation and audit system in place within a system of clinical governance.

Key words for search

Sexual assault, rape, crime, blood borne viruses, post exposure prophylaxis.

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June 2011

Appendix 1

Methodology

Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

Evidence Levels

1. Evidence from at least one systematic review of multiple well designed randomised control trials.
2. Evidence from at least one published properly designed randomised control trials of appropriate size and setting.
3. Evidence from well-designed trials without randomisation, single group pre/post, cohort, time series or matched case control studies.
4. Evidence from well-designed non experimental studies from more than one centre or research group.
5. Opinions, respected authority, clinical evidence, descriptive studies or consensus reports.

Strength of recommendation

We used the GRADE system. This categorises a recommendation into either strong or weak, depending on the quality of evidence and the likelihood of future evidence being available to alter the recommendation.