

Testing and Treating Sexually Assaulted Adolescents: What Are We Waiting For?

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A survey conducted by the Centers for Disease Control and Prevention (CDC) observed a very high rate of reported sexual assault among high school students, which occurred in 10% of girls surveyed.¹ Both the CDC^{2,3} and the American Academy of Pediatrics⁴⁻⁶ recommend routine testing and prophylaxis against infection and pregnancy for sexually assaulted adolescents. Although the rates of testing and prophylaxis among adult victims of sexual assault are low throughout US emergency departments (EDs),⁷⁻⁹ little is known about sexually transmitted infection (STI) testing and prophylaxis rates in adolescents.

In this issue of *Pediatrics*, Schilling et al describe the rates of STI testing and prophylaxis across pediatric hospital EDs and evaluate whether local guidelines and specialized sexual assault teams influence the rates of testing and prophylaxis.¹⁰ Thirty percent of the 38 hospitals in the Pediatric Health Information System reported having a clinical pathway for the care of patients with sexual assault, and 64% of hospitals reported having a specialized sexual assault team.

Rates of STI testing among the 12 687 adolescents included in this study were low (43% received all recommended testing) and varied widely across hospitals. STI testing was not influenced by the presence of a specialized sexual assault team or by the presence of a care pathway. Rates of STI prophylaxis were also very low; only 35% of patients received the recommended prophylaxis against gonorrhea, chlamydia, and pregnancy. Although the presence of a specialized

sexual assault team was not associated with STI testing rates, adolescents cared for at hospitals with a sexual assault care pathway were 50% more likely to receive prophylaxis. These data highlight the widespread variation and perhaps suboptimal care adolescent victims of sexual assault receive. It also highlights the fact that specialized sexual assault teams, and guidelines, in isolation, may not influence care to a great extent.

The reasons for the low rates of STI testing and prophylaxis are probably multifactorial. Some adolescents may not seek care immediately after the assault, and testing and prophylaxis rates may understandably be lower among these children; however, the validation substudy indicated that 92% were seen within 120 hours of the assault. Although a majority of survey respondents in this study would still recommend testing and prophylaxis beyond the 5-day window, fewer than half received any testing or prophylaxis, suggesting poor clinician uptake. Also, some of the children included in this study may have received outpatient STI prophylaxis, which would result in an underreporting in the rate of treatment, because the Pediatric Health Information System database captures only medication billed during the ED encounter. However, clinicians should realize that compliance with prescribed medications and follow-up after sexual assault are low among adolescents^{11,12}; therefore, physicians should strongly consider administering prophylactic medications during the encounter, in accordance with CDC guidelines. It is possible that some adolescents

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Opinions expressed in these commentaries are those of the author and not necessarily those of the American Academy of Pediatrics or its Committees.

Drs Neuman and Kellogg drafted the initial manuscript, and both authors approved the final manuscript as submitted.

www.pediatrics.org/cgi/doi/10.1542/peds.2015-3346

DOI: 10.1542/peds.2015-3346

Accepted for publication Sep 8, 2015

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PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

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FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

FUNDING: No external funding.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

COMPANION PAPER: A companion to this article can be found on page e1495, online at www.pediatrics.org/cgi/doi/10.1542/peds.2015-2093.

declined any testing or treatment; the variability in testing and treating rates between hospitals suggests that providers can be more effective in overcoming such barriers. Lastly, approximately one-quarter of the EDs surveyed raised concerns about the legal implications of testing, in that negative results may be used to refute the allegations of sexual assault and that positive results may be used to question the patient's credibility by implicating previous sexual activity.

The use of administrative data to assess prophylaxis rates is limited to the use of diagnosis codes for case identification. As a result, some of the patients included in this study may not have been appropriate candidates for STI testing or prophylaxis. For example, it is possible that some diagnosed with child sexual abuse (International Classification of Diseases code 995.53) did not experience genital-genital or other types of sexual contact that would result in transmission of an STI and accordingly were not tested or treated. Although patient-level factors may account in part for low rates of testing and prophylaxis, the significant discrepancies between reported and actual rates of testing and prophylaxis suggest that hospital-level factors should be examined to identify opportunities to improve care for this patient population. If the findings of this study are replicated, the barriers to STI testing and prophylaxis should be identified to ensure appropriate care for sexually assaulted adolescents.

Sexually assaulted adolescents typically present to an ED setting with medical and mental health needs. Those with STIs, whether

preexisting or caused by sexual assault, are often asymptomatic. Testing ensures that STIs are detected and often facilitates follow-up for the victim and partners, when appropriate. Prophylactic treatment of STIs and pregnancy brings relief for some patients concerned about adverse outcomes from their assault. This article identifies variability and discrepancies in the provision of care to sexually assaulted adolescents; clinicians are now challenged to identify and address the barriers to providing appropriate medical care for this patient population.

ACKNOWLEDGMENT

We thank Dr Daniel Lindberg for his review of this article.

ABBREVIATIONS

CDC: Centers for Disease Control and Prevention

ED: emergency department

STI: sexually transmitted infection

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Pediatrics 2015;136:e1600

DOI: 10.1542/peds.2015-3346 originally published online November 2, 2015;

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The online version of this article, along with updated information and services, is located on the World Wide Web at:

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