NO. _____

THE STATE OF TEXAS	§	IN THE DISTRICT COURT
V.	§	_____ JUDICIAL DISTRICT
_____	§	BEXAR COUNTY, TEXAS

SID #_____
D.O.B. _____

ORDER

Pursuant to Article 21.31 of the Texas Code of Criminal Procedure, it is hereby ordered that _____, hereinafter referred to as defendant, who has been indicted for or who has waived indictment for \data:mCase:ChargesFiledAgain2:ChargeDesc\, an offense under Section 21.02, 21.11(a)(1), 22.011, or 22.021, Texas Penal Code shall undergo a medical procedure or test designed to show or help show whether the defendant has an acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection, antibodies to HIV, or infection with any other probable causative agent of AIDS, or any other sexually transmitted disease or reportable disease under Section 81.048, Health and Safety Code, including but not limited to gonorrhea, chlamydia, syphilis, hepatitis B, and hepatitis C.

It is further ordered that the defendant submit to this medical testing or procedure **within ten business (10)** days from the date of receipt of service of this Order. If the defendant is free on bond or probation, testing will take place at University Health System, Robert B. Green Campus, 903 W. Martin, San Antonio, Texas 78207 (210) 358-3635, on Monday through Friday (excluding holidays), between the hours of 9:00 a.m. and 4:00 p.m. Defendant should report directly to the laboratory for testing. If the defendant is in custody, the tests will be done at the Bexar County Adult Detention Facility; however, this Order will allow for the transfer of the defendant inmate to any UHS facility for testing in accordance with the rules and procedures of Bexar County Adult Detention Facility. **Defendant may be charged with contempt of court for failure to timely comply with this Court Order.**

It is further ordered that the person conducting the procedure or the test shall make the test results available to the local health authority, and the local health authority shall be required to provide notification of the test results to the victim of the alleged offense, or their parent or guardian if the victim is a minor, whose name shall be disclosed for reporting purposes only to the local health authority through the Victim Assistance Coordinator of the Bexar County District Attorney's Office, and to the defendant.

It is further ordered that the Sheriff's Office shall serve this Order upon the Defendant, and copies of this Order shall be sent to The University Health System, 903 W. Martin, San Antonio, Texas 78207; the Bexar County Adult Detention Center (if applicable); and the Victim's Assistance Unit of the District Attorney's Office, all in **sealed envelopes** from the court marked **"confidential"** by the Bexar County District Clerk's Office.

SIGNED, ORDERED and ENTERED on the _____ day of _____, 201__.

_____
JUDGE PRESIDING
_____ th JUDICIAL DISTRICT COURT
BEXAR COUNTY, TEXAS

SHERIFF'S RETURN

CAME TO HAND ON THE DAY ISSUED AND EXECUTED _____ IMMEDIATELY DELIVERING THIS CERTIFIED COPY OF HIV/AIDS TESTING ORDER IN CAUSE NO. _____ TO THE WITHIN NAMED DEFENDANT _____ IN PERSON.

_____
SHERIFF OF BEXAR COUNTY, TEXAS
BY: _____ DEPUTY

Family Code Sec. 54.033.

SEXUALLY TRANSMITTED DISEASE, AIDS, AND HIV TESTING.

(a) A child found at the conclusion of an adjudication hearing under Section 54.03 of this code to have engaged in delinquent conduct that included a violation of Sections 21.11(a)(1), 22.011, or 22.021, Penal Code, shall undergo a medical procedure or test at the direction of the juvenile court designed to show or help show whether the child has a sexually transmitted disease, acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV) infection, antibodies to HIV, or infection with any other probable causative agent of AIDS. The court may direct the child to undergo the procedure or test on the court's own motion or on the request of the victim of the delinquent conduct.

(b) If the child or another person who has the power to consent to medical treatment for the child refuses to submit voluntarily or consent to the procedure or test, the court shall require the child to submit to the procedure or test.

(c) The person performing the procedure or test shall make the test results available to the local health authority. The local health authority shall be required to notify the victim of the delinquent conduct and the person found to have engaged in the delinquent conduct of the test result.

(d) The state may not use the fact that a medical procedure or test was performed on a child under this section or use the results of the procedure or test in any proceeding arising out of the delinquent conduct.

(e) Testing under this section shall be conducted in accordance with written infectious disease control protocols adopted by the Texas Board of Health that clearly establish procedural guidelines that provide criteria for testing and that respect the rights of the child and the victim of the delinquent conduct.

(f) Nothing in this section allows a court to release a test result to anyone other than a person specifically authorized under this section. Section 81.103(d), Health and

Safety Code, may not be construed to allow the disclosure of test results under this section except as provided by this section.

Code of Criminal Procedure Art. 17.45.
CONDITIONS REQUIRING AIDS AND HIV INSTRUCTION.

A magistrate may require as a condition of bond that a defendant charged with an offense under Section 43.02, Penal Code, receive counseling or education, or both, relating to acquired immune deficiency syndrome or human immunodeficiency virus.

Code of Criminal Procedure Art. 18.22.
TESTING CERTAIN DEFENDANTS OR CONFINED PERSONS FOR COMMUNICABLE DISEASES.

Text of subsection as amended by Acts 2015, 84th Leg., R.S., Ch. 736 (H.B. 1595), Sec. 2

(a) A person who is arrested for a misdemeanor or felony and who during the commission of that offense or the arrest, during a judicial proceeding or initial period of confinement following the arrest, or during the person's confinement after a conviction or adjudication resulting from the arrest causes the person's bodily fluids to come into contact with a peace officer, a magistrate, or an employee of a correctional facility where the person is confined shall, at the direction of the court having jurisdiction over the arrested person, undergo a medical procedure or test designed to show or help show whether the person has a communicable disease. The court may direct the person to undergo the procedure or test on its own motion or on the request of the peace officer, magistrate, or correctional facility employee. If the person refuses to submit voluntarily to the procedure or test, the court shall require the person to submit to the procedure or test. Notwithstanding any other law,

the person performing the procedure or test shall make the test results available to the local health authority, and the local health authority shall notify the peace officer, magistrate, or correctional facility employee, as appropriate, of the test result. The state may not use the fact that a medical procedure or test was performed on a person under this article, or use the results of the procedure or test, in any criminal proceeding arising out of the alleged offense.

Text of subsection as amended by Acts 2015, 84th Leg., R.S., Ch. 1278 (S.B. 1574), Sec. 1

(a) A person who is arrested for a misdemeanor or felony and who during the commission of that offense or an arrest following the commission of that offense causes an emergency response employee or volunteer, as defined by Section 81.003, Health and Safety Code, to come into contact with the person's bodily fluids shall, at the direction of the court having jurisdiction over the arrested person, undergo a medical procedure or test designed to show or help show whether the person has a communicable disease. The court may direct the person to undergo the procedure or test on its own motion or on the request of the emergency response employee or volunteer. If the person refuses to submit voluntarily to the procedure or test, the court shall require the person to submit to the procedure or test. Notwithstanding any other law, the person performing the procedure or test shall make the test results available to the local health authority and the designated infection control officer of the entity that employs or uses the services of the affected emergency response employee or volunteer, and the local health authority or the designated infection control officer of the affected employee or volunteer shall notify the emergency response employee or volunteer of the test result. The state may not use the fact that a medical procedure or test was performed on a person under this article,

or use the results of the procedure or test, in any criminal proceeding arising out of the alleged offense.

(b) Testing under this article shall be conducted in accordance with written infectious disease control protocols adopted by the Department of State Health Services that clearly establish procedural guidelines that provide criteria for testing and that respect the rights of the arrested person and the peace officer, magistrate, or correctional facility employee.

(c) Nothing in this article authorizes a court to release a test result to a person other than a person specifically authorized by this article, and Section 81.103(d), Health and Safety Code, does not authorize that disclosure.

(d) In this article, "correctional facility" means:

(1) any place described by Section 1.07(a)(14), Penal Code; or

(2) a "secure correctional facility" or "secure detention facility" as those terms are defined by Section 51.02, Family Code.

Code of Criminal Procedure Art. 21.31.

TESTING FOR AIDS AND CERTAIN OTHER DISEASES.

(a) A person who is indicted for or who waives indictment for an offense under Section 21.02, 21.11(a)(1), 22.011, or 22.021, Penal Code, shall, at the direction of the court on the court's own motion or on the request of the victim of the alleged offense, undergo a standard diagnostic test approved by the United States Food and Drug Administration for human immunodeficiency virus (HIV) infection and other sexually transmitted diseases. If the person refuses to submit voluntarily to the test, the court shall require the person to submit to the test. On request of the victim of the alleged offense, the court shall order the defendant to undergo the test not later than 48 hours after an indictment for the offense is presented against the defendant or the defendant waives indictment. Except as provided by Subsection (b-1), the court

may require a defendant previously required under this article to undergo a diagnostic test on indictment for an offense to undergo a subsequent test only after conviction of the offense. A person performing a test under this subsection shall make the test results available to the local health authority, and the local health authority shall be required to make the notification of the test results to the victim of the alleged offense and to the defendant.

(a-1) If the victim requests the testing of the defendant and a law enforcement agency is unable to locate the defendant during the 48-hour period allowed for that testing under Subsection (a), the running of the 48-hour period is tolled until the law enforcement agency locates the defendant and the defendant is present in the jurisdiction.

(b) The court shall order a person who is charged with an offense under Section 22.11, Penal Code, to undergo in the manner provided by Subsection (a) a diagnostic test designed to show or help show whether the person has HIV, hepatitis A, hepatitis B, tuberculosis, or any other disease designated as a reportable disease under Section 81.048, Health and Safety Code. The person charged with the offense shall pay the costs of testing under this subsection.

(b-1) If the results of a diagnostic test conducted under Subsection (a) or (b) are positive for HIV, the court shall order the defendant to undergo any necessary additional testing within a reasonable time after the test results are released.

(c) The state may not use the fact that a test was performed on a person under Subsection (a) or use the results of a test conducted under Subsection (a) in any criminal proceeding arising out of the alleged offense.

(d) Testing under this article shall be conducted in accordance with written infectious disease control protocols adopted by the Texas Board of Health that clearly establish procedural guidelines that provide criteria for testing and that respect the rights of the person accused and any victim of the alleged offense.

(e) This article does not permit a court to release a test result to anyone other than those authorized by law, and the provisions of Section 81.103(d), Health and Safety Code, may not be construed to allow that disclosure.

Code of Criminal Procedure Art. 56.021.
RIGHTS OF VICTIM OF SEXUAL ASSAULT OR ABUSE, STALKING, OR TRAFFICKING.

(a) In addition to the rights enumerated in Article 56.02, if the offense is a sexual assault, the victim, guardian of a victim, or close relative of a deceased victim is entitled to the following rights within the criminal justice system:

(4) if requested, the right to counseling regarding acquired immune deficiency syndrome (AIDS) and human immunodeficiency virus (HIV) infection;

(5) for the victim of the offense, testing for acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV) infection, antibodies to HIV, or infection with any other probable causative agent of AIDS; and

(6) to the extent provided by Articles 56.06 and 56.065, for the victim of the offense, the right to a forensic medical examination if, within 96 hours of the offense, the offense is reported to a law enforcement agency or a forensic medical examination is otherwise conducted at a health care facility.

(b) A victim, guardian, or relative who requests to be notified under Subsection (a)(3) must provide a current address and phone number to the attorney representing the state and the law enforcement agency that is investigating the offense. The victim, guardian, or relative must inform the attorney representing the state and the law enforcement agency of any change in the address or phone number.

(c) A victim, guardian, or relative may designate a person, including an entity that provides services to victims of

sexual assault, to receive any notice requested under Subsection (a)(3).

CODE OF CRIMINAL PROCEDURE Art. 46A.01.

TESTING; SEGREGATION; DISCLOSURE.

(a) In this article "AIDS" and "HIV" have the meanings assigned those terms by Section 81.101, Health and Safety Code.

(b) A county or municipality may test an inmate confined in the county or municipal jail or in a contract facility authorized by Article 5115d, Revised Statutes, or Article 5115e, Revised Statutes, to determine the proper medical treatment of the inmate or the proper social management of the inmate or other inmates in the jail or facility.

(c) If the county or municipality determines that an inmate has a positive test result for AIDS or HIV, the county or municipality may segregate the inmate from other inmates in the jail or facility.

(d) This article does not provide a duty to test for AIDS or HIV, and a cause of action does not arise under this article from a failure to test for AIDS or HIV.

Sexual Assault and Abuse and STDs

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Adolescents and Adults

These guidelines are primarily limited to the identification, prophylaxis, and treatment of STDs and conditions among adolescent and adult female sexual assault survivors. However, some of the following guidelines might still apply to male sexual assault survivors. The documentation of findings, collection of nonmicrobiologic specimens for forensic purposes, and the management of potential pregnancy or physical and psychological trauma are beyond the scope of these guidelines.

Examinations of survivors of sexual assault should be conducted by an experienced clinician in a way that minimizes further trauma to the survivor. The decision to obtain genital or other specimens for STD diagnosis should be made on an individual basis. Care systems for survivors should be designed to ensure continuity (including timely review of test results), support adherence, and monitor adverse reactions to any prescribed therapeutic or prophylactic regimens. Laws in all 50 states strictly limit the evidentiary use of a survivor's previous sexual history, including evidence of previously acquired STDs, 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. Although it rarely occurs, STD diagnoses might later be accessed, and the survivor and clinician might opt to defer testing for this reason. While collection of specimens at initial examination for laboratory STD diagnosis gives the survivor and clinician the option to defer empiric prophylactic antimicrobial treatment, compliance with follow-up visits is typically poor (*866,867*). Among sexually active adults, the identification of an STD might represent an infection acquired before the assault, and therefore might be more important for the medical management of the patient than for legal purposes.

Trichomoniasis, BV, gonorrhea, and chlamydial infection are the most frequently diagnosed infections among women who have been sexually assaulted. Such conditions are prevalent in the population, and detection of these infections after an assault does not necessarily imply acquisition during the assault. However, a post-assault examination presents an important opportunity to identify or prevent STDs. Chlamydial and gonococcal infections in women are of particular concern because of the possibility of ascending infection. In addition, HBV infection can be prevented through postexposure vaccination (see Hepatitis B, Table 5). Because female survivors also are at risk for acquiring HPV infection and the efficacy of the HPV vaccine is high (*868,869*), HPV vaccination is also recommended for females through age 26 years (*16*). Reproductive-aged female survivors should be evaluated for pregnancy.

Evaluating Adolescents and Adults for STDs

Initial Examination

Decisions to perform these tests should be made on an individual basis. An initial examination might include the following procedures:

- NAATs for *C. trachomatis* and *N. gonorrhoeae* at the sites of penetration or attempted penetration (*394*). These tests are preferred for the diagnostic evaluation of adolescent or adult sexual assault survivors.
- NAATs from a urine or vaginal specimen or point-of-care testing (i.e., DNA probes) from a vaginal specimen for *T. vaginalis*. Point-of-care testing and/or wet mount with measurement of vaginal pH and KOH application for the whiff test from vaginal secretions should be done for evidence of BV and candidiasis, especially if vaginal discharge, malodor, or itching is present.
- A serum sample for evaluation of HIV, hepatitis B, and syphilis infections.

Treatment

Compliance with follow-up visits is poor among survivors of sexual assault (*866,867*). As a result, the following routine presumptive treatment after a sexual assault is recommended:

- An empiric antimicrobial regimen for chlamydia, gonorrhea, and trichomonas.
- Emergency contraception. This measure should be considered when the assault could result in pregnancy in the survivor.
- Postexposure hepatitis B vaccination (without HBIG) if the hepatitis status of the assailant is unknown and the survivor has not been previously vaccinated. If the assailant is known to be HBsAg-positive, unvaccinated survivors should receive both hepatitis B vaccine and HBIG. The vaccine and HBIG, if indicated, should be administered to sexual assault survivors at the time of the initial examination, and follow-up doses of vaccine should be administered 1–2 and 4–6 months after the first dose. Survivors who were previously vaccinated but did not receive postvaccination testing should receive a single vaccine booster dose (see hepatitis B).
- HPV vaccination is recommended for female survivors aged 9–26 years and male survivors aged 9–21 years. For MSM with who have not received HPV vaccine or who have been incompletely vaccinated, vaccine can be administered through age 26 years. The vaccine should be administered to sexual assault survivors at the time of the initial examination, and follow-up dose administered at 1–2 months and 6 months after the first dose.
- Recommendations for HIV PEP are individualized according to risk (see Risk for Acquiring HIV Infection and Postexposure HIV Risk Assessment for PEP).

Recommended Regimens

Ceftriaxone 250 mg IM in a single dose
PLUS

Azithromycin 1 g orally in a single dose
PLUS

Metronidazole 2 g orally in a single dose
OR

Tinidazole 2 g orally in a single dose

If alcohol has been recently ingested or emergency contraception is provided, metronidazole or tinidazole can be taken by the sexual assault survivor at home rather than as directly observed therapy to minimize potential side effects and drug interactions. Clinicians should counsel persons regarding the possible benefits and toxicities associated with these treatment regimens; gastrointestinal side effects can occur with this combination. The efficacy of these regimens in preventing infections after sexual assault has not been evaluated. For those requiring alternative treatments, refer to the specific sections in this report relevant to the specific organism.

Other Management Considerations

At the initial examination and, if indicated, at follow-up examinations, patients should be counseled regarding symptoms of STDs and the need for immediate examination if symptoms occur. Further, they should be instructed to abstain from sexual intercourse until STD prophylactic treatment is completed.

Follow-up

After the initial post-assault examination, follow-up examinations provide an opportunity to 1) detect new infections acquired during or after the assault; 2) complete hepatitis B and HPV vaccinations, if indicated; 3) complete counseling and treatment for other STDs; and 4) monitor side effects and adherence to postexposure prophylactic medication, if prescribed.

If initial testing was done, follow-up evaluation should be conducted within 1 week to ensure that results of positive tests can be discussed promptly with the survivor, treatment is provided if not given at the initial visit, and any follow-up for the infection(s) can be arranged. If initial tests are negative and treatment was not provided, examination for STDs can be repeated within 1–2 weeks of the assault; repeat testing detects infectious organisms that might not have reached sufficient concentrations to produce positive test results at the time of initial examination. For survivors who are treated during the initial visit, regardless of whether testing was performed, post-treatment testing should be conducted only if the survivor reports having symptoms. A follow-up examination at 1–2 months should also be considered to reevaluate for development of anogenital warts, especially among sexual assault survivors who received a diagnosis of other STDs. If initial test results were negative and infection in the assailant cannot be ruled out, serologic tests for syphilis can be repeated at 4–6 weeks and 3 months; HIV testing can be repeated at 6 weeks and at 3 and 6 months using methods to identify acute HIV infection (see Sexual Assault and STDs, Risk for Acquiring HIV Infection).

Risk for Acquiring HIV Infection

HIV seroconversion has occurred in persons whose only known risk factor was sexual assault or sexual abuse, but the frequency of this occurrence likely is low (*870,871*). In consensual sex, the per-act risk for HIV transmission from vaginal intercourse is 0.1%–0.2%, and for receptive rectal intercourse, 0.5%–3% (*872*). The per-act risk for HIV transmission from oral sex is substantially lower. Specific circumstances of an assault (e.g., bleeding, which often accompanies trauma) might increase risk for HIV transmission in cases involving vaginal, anal, or oral penetration. Site of exposure to ejaculate, viral load in ejaculate, and the presence of an STD or genital lesions in the assailant or survivor also might increase risk for HIV.

Postexposure prophylaxis with a 28-day course of zidovudine was associated with an 81% reduction in risk for acquiring HIV in a study of health-care workers who had percutaneous exposures to HIV-infected blood (*873*). On the basis of these results and results from animal studies, PEP has been recommended for health-care workers who have occupational exposures to HIV (*874*). These findings have been extrapolated to nonoccupational injection and sexual HIV exposures, including sexual assault. The possibility of HIV exposure from the assault should be assessed at the initial examination; survivors determined to be at risk for HIV should be informed about the possible benefit of nonoccupational postexposure prophylaxis (nPEP) in preventing HIV infection. Initiation of nPEP as soon as possible after the exposure increases the likelihood of prophylactic benefit.

Several factors impact the medical recommendation for nPEP and affect the assault survivor's acceptance of that recommendation, including 1) the likelihood of the assailant having HIV; 2) any exposure characteristics that might increase the risk for HIV transmission; 3) the time elapsed after the event; and 4) the potential benefits and risks associated with the nPEP (*312*). Determination of the assailant's HIV status at the time of the assault examination is usually not possible. Therefore, health-care providers should assess any available information concerning the 1) characteristics and HIV risk behaviors of the assailant(s) (e.g., being an MSM or using injection drugs), 2) local epidemiology of HIV/AIDS, and 3) exposure characteristics of the assault. When an assailant's HIV status is unknown, determinations regarding risk for HIV transmission to the survivor should be based on 1) whether vaginal or anal penetration occurred; 2) whether ejaculation occurred on mucous membranes; 3) whether multiple assailants were involved; 4) whether mucosal lesions are present in the assailant or survivor; and 5) any other characteristics of the assault, survivor, or assailant that might increase risk for HIV transmission.

If nPEP is offered, the following information should be discussed with the survivor: 1) the necessity of early initiation of nPEP to optimize potential benefits (i.e., as soon as possible after and up to 72 hours after the assault; 2) the importance of close follow-up; 3) the benefit of adherence to recommended dosing; and 4) potential adverse effects of antiretrovirals. Providers should emphasize that severe adverse effects are rare from nPEP (*875-877*). Clinical management of the survivor should be implemented according to the HIV nPEP guidelines and in collaboration with specialists (*312*). However, distress after an assault also might prevent the survivor from accurately weighing exposure risks and benefits of nPEP and from making an informed decision regarding initiating therapy, even when such therapy is considered

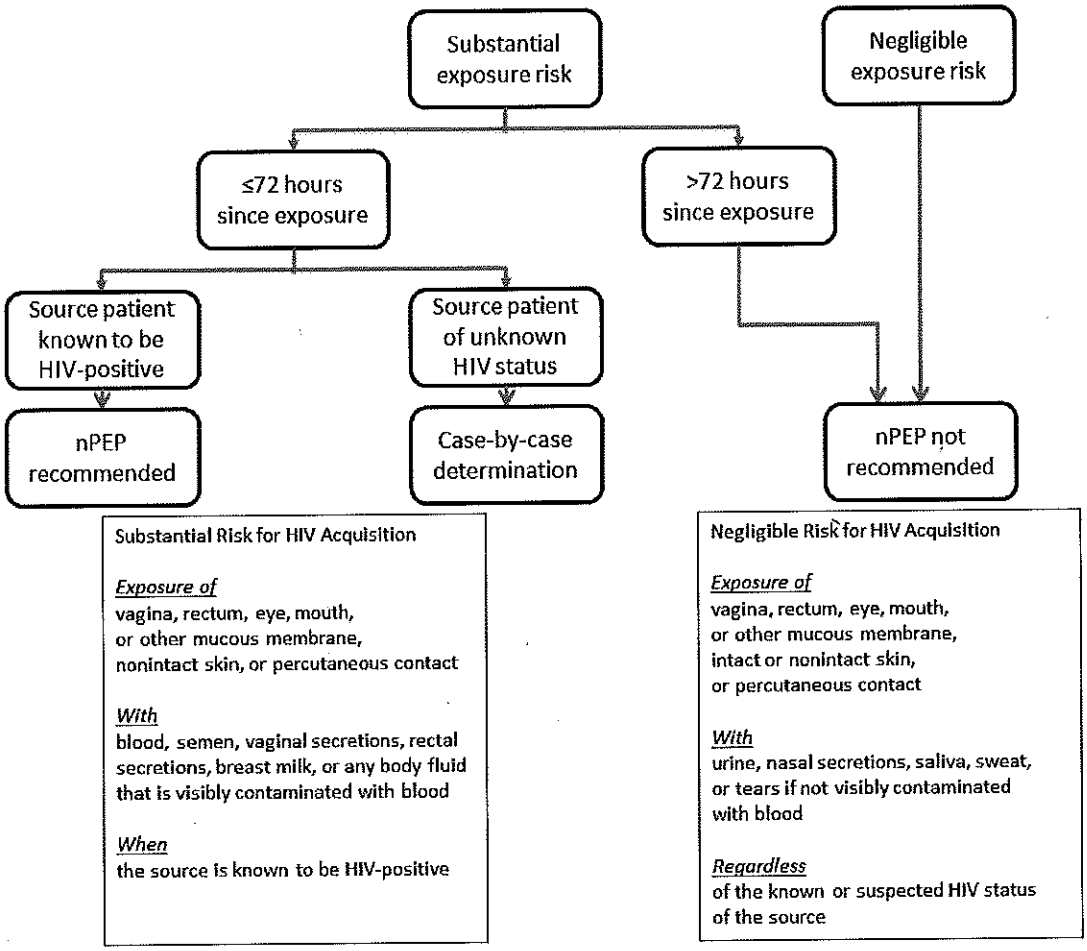
warranted by the health-care provider. In this instance, the survivor can be provided a 3–5-day supply of nPEP and scheduled for follow-up at a time that allows for provision of the remaining 23 days of medication (if nPEP has been initiated by the survivor) without interruption in dosing. A follow-up visit also creates opportunity for additional counseling as needed.

Recommendations for postexposure HIV risk assessment of adolescent and adult survivors within 72 hours of sexual assault

- Assess risk for HIV infection in the assailant, and test that person for HIV whenever possible.
- Use the algorithm to evaluate the survivor for the need for HIV nPEP (Figure) (*312*).
- Consult with a specialist in HIV treatment if nPEP is being considered.
- If the survivor appears to be at risk for acquiring HIV from the assault, discuss nPEP, including benefits and risks.
- If the survivor chooses to start nPEP (*312*), provide enough medication to last until the follow-up visit at 3–7 days after initial assessment and assess tolerance to medications.
- If nPEP is started, perform CBC and serum chemistry at baseline.
- Perform an HIV antibody test at original assessment; repeat at 6 weeks, 3 months, and 6 months.

Assistance with nPEP-related decisions can be obtained by calling the National Clinician's Post Exposure Prophylaxis Hotline (PEP Line) (telephone: 888–448–4911).

FIGURE. Algorithm for evaluation and treatment of possible nonoccupational HIV exposures



Source: CDC. Antiretroviral postexposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV in the United States. MMWR Recomm Rep 2005;54(No. RR-02):1–20.

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Sexual Assault or Abuse of Children

These guidelines are limited to the identification and treatment of STDs in pre-pubertal children. Management of the psychosocial or legal aspects of the sexual assault or abuse of children is beyond the scope of these guidelines.

The identification of sexually transmissible agents in children beyond the neonatal period strongly suggests sexual abuse (*878*). The significance of the identification of a sexually transmitted organism in such children as evidence of possible child sexual abuse varies by pathogen. Postnatally acquired gonorrhea and syphilis; chlamydia infection; and nontransfusion, nonperinatally acquired HIV are indicative of sexual abuse. Chlamydia infection might be indicative of sexual abuse in children ≥3 years of age and among those aged <3 years when infection is not likely perinatally acquired. Sexual abuse should be suspected when genital herpes, *T. vaginalis*, or anogenital warts are diagnosed. The investigation of sexual abuse among children who have an infection that could have been transmitted sexually should be conducted in compliance with recommendations by clinicians who have experience and training in all elements of the evaluation of child abuse, neglect, and assault. The social

significance of an infection that might have been acquired sexually varies by the specific organism, as does the threshold for reporting suspected child sexual abuse (Table 6). In cases in which any STD has been diagnosed in a child, efforts should be made in consultation with a specialist to evaluate the possibility of sexual abuse, including conducting a history and physical examination for evidence of abuse and diagnostic testing for other commonly occurring STDs (*879,880*).

The general rule that sexually transmissible infections beyond the neonatal period are evidence of sexual abuse has exceptions. For example, genital infection with *T. vaginalis* (*881*) or rectal or genital infection with *C. trachomatis* among young children might be the result of perinatally acquired infection and has, in some cases of chlamydia infection, persisted for as long as 2–3 years (*882,883*), though perinatal CT infection is now uncommon because of prenatal screening and treatment of pregnant women. Genital warts have been diagnosed in children who have been sexually abused (*868*), but also in children who have no other evidence of sexual abuse (*884,885*). BV has been diagnosed in children who have been abused, but its presence alone does not prove sexual abuse. Most HBV infections in children result from household exposure to persons who have chronic HBV infection rather than sexual abuse.

TABLE 6. Implications of commonly encountered sexually transmitted or sexually associated infections for diagnosis and reporting of sexual abuse among infants and prepubertal children

ST/SA confirmed	Evidence for sexual abuse	Suggested action
Gonorrhea*	Diagnostic	Report†
Syphilis*	Diagnostic	Report†
HIV§	Diagnostic	Report†
*Chlamydia trachomatis**	Diagnostic	Report†
*Trichomonas vaginalis**	Highly suspicious	Report†
Genital herpes	Highly suspicious (HSV-2 especially)	Report†,¶
Condylomata acuminata (anogenital warts)*	Suspicious	Consider report†,¶,**
Bacterial vaginosis	Inconclusive	Medical follow-up

Source: Adapted from Kellogg N, American Academy of Pediatrics Committee on Child Abuse and Neglect. The evaluation of child abuse in children. Pediatrics 2005;116:506–12.

Abbreviations: HIV = human immunodeficiency virus; SA = sexually associated; ST = sexually transmitted.

* If not likely to be perinatally acquired and rare vertical transmission is excluded.

† Reports should be made to the agency in the community mandated to receive reports of suspected child abuse or neglect.

§ If not likely to be acquired perinatally or through transfusion.

¶ Unless a clear history of autoinoculation exists.

** Report if evidence exists to suspect abuse, including history, physical examination, or other identified infections.

Reporting

All U.S. states and territories have laws that require the reporting of child abuse. Although the exact requirements differ by state, if a health-care provider has reasonable cause to suspect child abuse, a report must be made. Health-care providers should contact their state or local child-protection service agency regarding child-abuse reporting requirements in their states.

Evaluating Children for STDs

Evaluations of children for sexual assault or abuse should be conducted in a manner designed to minimize pain and trauma to the child. Examinations and collection of vaginal specimens in prepubertal children can be very uncomfortable and should be performed by an experienced clinician to avoid psychological and physical trauma to the child. The decision to obtain genital or other specimens from a child to evaluate for STDs must be made on an individual basis; however, children who received a diagnosis of one STD should be screened for all STDs. Because STDs are not common in prepubertal children or infants evaluated for abuse, testing all sites for all organisms is not routinely recommended. Factors that should lead the physician to consider screening for STD include (*878*):

1. Child has experienced penetration or has evidence of recent or healed penetrative injury to the genitals, anus, or oropharynx.
2. Child has been abused by a stranger.
3. Child has been abused by a perpetrator known to be infected with an STD or at high risk for STDs (e.g., intravenous drug abusers, MSM, persons with multiple sexual partners, and those with a history of STDs).
4. Child has a sibling, other relative, or another person in the household with an STD.
5. Child lives in an area with a high rate of STD in the community.
6. Child has signs or symptoms of STDs (e.g., vaginal discharge or pain, genital itching or odor, urinary symptoms, and genital lesions or ulcers).
7. Child or parent requests STD testing.

If a child has symptoms, signs, or evidence of an infection that might be sexually transmitted, the child should be tested for common STDs before the initiation of any treatment that could interfere with the diagnosis of those other STDs. Because of the legal and psychosocial consequences of a false-positive diagnosis, only tests with high specificities should be used. The potential benefit to the child of a reliable STD diagnosis justifies deferring presumptive treatment until specimens for highly specific tests are obtained by providers with experience in the evaluation of sexually abused and assaulted children.

Evaluations should be scheduled on a case-by-case basis according to history of assault or abuse and in a manner that minimizes the possibility for psychological trauma and social stigma. If the initial exposure was recent, the infectious organisms acquired through the exposure might not have produced sufficient concentrations of organisms to result in positive test results or examination findings (*886*). Alternatively, positive test results following a recent exposure might represent the assailant's secretions (but would nonetheless be an indication for treatment of the child). A second visit approximately 2 weeks after the most recent sexual exposure should be scheduled to include a repeat physical examination and collection of additional specimens to identify any infection that might not have been detected at the time of initial evaluation. A single evaluation might be sufficient if the child was abused for an extended period of time and if a substantial amount of time elapsed between the last suspected episode of abuse and the medical evaluation. Compliance with follow-up appointments might be improved when law enforcement personnel or child protective services are involved.

Initial Examination

The following should be performed during the initial examination.

- Visual inspection of the genital, perianal, and oral areas for genital discharge, odor, bleeding, irritation, warts, and ulcerative lesions. The clinical manifestations of some STDs are different in children than in adults. For example, typical vesicular lesions might be absent even in the presence of HSV infection. Because HSV can be indicative of sexual abuse, specimens should be obtained from all vesicular or ulcerative genital or perianal lesions and then sent for viral culture or PCR.
- Culture for *N. gonorrhoeae* from specimens collected from the pharynx and anus in boys and girls, the vagina in girls, and the urethra in boys. Cervical specimens are not recommended for prepubertal girls. For boys with a urethral discharge, a meatal specimen discharge is an adequate substitute for an intraurethral swab specimen. Because of the legal implications of a diagnosis of *N. gonorrhoeae* infection in a child, if culture for the isolation of *N. gonorrhoeae* is done, only standard culture procedures should be performed. Gram stains are inadequate to evaluate prepubertal children for gonorrhea and should not be used to diagnose or exclude gonorrhea. Specimens from the vagina, urethra, pharynx, or rectum should be streaked onto selective media for isolation of *N. gonorrhoeae*, and all presumptive isolates of *N. gonorrhoeae* should be identified definitively by at least two tests that involve different approaches (e.g., biochemical, enzyme substrate, or serologic). Isolates should be preserved to enable additional or repeated testing. Data on use of NAAT for detection of *N. gonorrhoeae* in children are limited, and performance is test dependent (*394*). Consultation with an expert is necessary before using NAAT in this context, both to minimize the possibility of cross-reaction with nongonococcal *Neisseria* species and other commensals (e.g., *N. meningitidis*, *N. sicca*, *N. lactamica*, *N. cinerea*, and *Moraxella catarrhalis*) and to ensure appropriate interpretation of positive results. When testing vaginal secretions or urine from girls, NAAT can be used as an alternative to culture; however, culture remains the preferred method for testing urethral specimens or urine from boys and extragenital specimens (pharynx and rectum) from all children (*394*). All positive specimens should be retained for additional testing.
- Culture for *C. trachomatis* from specimens collected from the anus in both boys and girls and from the vagina in girls. The likelihood of recovering *C. trachomatis* from the urethra of prepubertal boys is too low to justify the trauma involved in obtaining an intraurethral specimen. However, a meatal specimen should be obtained if urethral discharge is present. Pharyngeal specimens for *C. trachomatis* are not recommended for children of either sex because the likelihood of recovering chlamydia is low, perinatally acquired infection might persist beyond infancy, and culture systems in some laboratories do not distinguish between *C. trachomatis* and *C. pneumoniae*. Only standard culture systems for the isolation of *C. trachomatis* should be used. The isolation of *C. trachomatis* should be confirmed by microscopic identification of inclusions by staining with fluorescein-conjugated monoclonal antibody specific for *C. trachomatis*. Isolates should be preserved for additional testing. Nonculture tests for chlamydia (e.g., DFA) are not specific enough for use in cases of possible child abuse or assault. NAATs can be used for detection of *C. trachomatis* in vaginal specimens or urine from girls (*394*). No data are available regarding the use of NAAT from urine in boys or for extragenital specimens (e.g., those obtained from the rectum) in boys and girls. Culture remains the preferred method for extragenital sites. All specimens should be retained for additional testing.
- Culture for *T. vaginalis* infection and wet mount of a vaginal swab specimen for *T. vaginalis* infection. Testing for *T. vaginalis* should not be limited to girls with vaginal discharge if other indications for vaginal testing exist, as there is some evidence to indicate that asymptomatic sexually abused children might be infected with *T. vaginalis* and might benefit from treatment (*887,888*). Data on use of NAAT for detection of *T. vaginalis* in children are too limited to inform recommendations, but no evidence suggests that performance of NAAT for detection of *T. vaginalis* in children would differ from that in adults.
- Wet mount of a vaginal swab specimen for BV.
- Collection of serum samples to be evaluated, preserved for subsequent analysis, and used as a baseline for comparison with follow-up serologic tests. Sera can be tested for antibodies to *T. pallidum*, HIV, and HBV. Decisions regarding the infectious agents for which to perform serologic tests should be made on a case-by-case basis.

Treatment

The risk of a child acquiring an STD as a result of sexual abuse or assault has not been well studied. Presumptive treatment for children who have been sexually assaulted or abused is not recommended because 1) the incidence of most STDs in children is low after abuse/assault, 2) prepubertal girls appear to be at lower risk for ascending infection than adolescent or adult women, and 3) regular follow-up of children usually can be ensured. However, some children or their parent(s) or guardian(s) might be concerned about the possibility of infection with an STD, even if the risk is perceived to be low by the health-care provider. Such concerns might be an appropriate indication for presumptive treatment in some settings and might be considered after all relevant specimens for diagnostic tests have been collected.

Other Management Considerations

Because child sexual-assault survivors are at increased risk for future unsafe sexual practices that have been linked to higher risk of HPV acquisition (*868,889*) and are more likely to engage in these behaviors at an earlier age, ACIP recommends vaccination of children who are victims of sexual abuse or assault at age ≥9 years who have not initiated or completed immunization (see HPV prevention section) (*16*). Although HPV vaccine will not protect against progression of infection already acquired or

promote clearance of the infection, the vaccine protects against vaccine types not yet acquired.

Follow-Up

If no infections were identified at the initial examination after the last suspected sexual exposure and if this exposure was recent, a follow-up evaluation approximately 2 weeks after the last exposure can be considered. Likewise, if no physical examination or diagnostic testing was done at the initial visit, then a complete examination can be scheduled approximately 2 weeks after the last exposure to identify any evidence of STDs.

In circumstances in which transmission of syphilis, HIV, hepatitis B, or HPV is a concern but baseline tests for syphilis, HIV, and HBV are negative and examinations for genital warts are negative, follow-up serologic testing and an examination approximately 6 weeks and 3 months after the last suspected sexual exposure is recommended to allow time for antibodies to develop and signs of infection to appear. In addition, results of HBsAg testing must be interpreted carefully, because HBV can be transmitted nonsexually. Decisions regarding which tests should be performed must be made on an individual basis.

Risk for Acquiring HIV Infection

HIV infection has been reported in children for whom sexual abuse was the only known risk factor. Children might be at higher risk for HIV acquisition than adolescent and adult sexual assault or sexual abuse survivors because the sexual abuse of children is frequently associated with multiple episodes of assault and mucosal trauma might be more likely. Serologic testing for HIV infection should be considered for sexually abused children. The decision to test for HIV infection should involve the family, if possible, and be made on a case-by-case basis depending on the likelihood of infection among assailant(s) (*890*). Although data are insufficient concerning the efficacy of nPEP among children, treatment is well tolerated by infants and children with and without HIV infection, and children have a minimal risk for serious adverse reactions because of the short period recommended for prophylaxis (*312,891*). In considering whether to offer nPEP, health-care providers should consider whether the child can be treated soon after the sexual exposure (i.e., within 72 hours), the likelihood that the assailant is infected with HIV, and the likelihood of high compliance with the prophylactic regimen. The potential benefit of treating a sexually abused child should be weighed against the risk for adverse reactions. If nPEP is being considered, a provider specializing in evaluating or treating children with HIV infection should be consulted.

Recommendations for Postexposure HIV Risk Assessment of Children within 72 Hours of Sexual Assault

- Review HIV/AIDS local epidemiology, assess risk for HIV infection in the assailant, and test for HIV infection.
- Evaluate circumstances of assault that might affect risk for HIV transmission.
- Consult with a specialist in treating children with HIV infection to select age-appropriate dosing and regimens if nPEP is considered.
- For children determined to be at risk for HIV transmission from the assault, discuss nPEP with the caregiver(s), including its toxicity, unknown efficacy, and possible benefits.
- If nPEP is begun, adequate doses of medication should be provided to last until the follow-up visit at 3–7 days after the initial assessment, at which time the child should be reevaluated and tolerance of medication assessed (*105,312,892*).
- If nPEP is started, perform CBC and serum chemistry at baseline.
- Perform HIV antibody testing during the original assessment and again at 6 weeks, 3 months, and 6 months after the assault.

* STI is the term used by USPSTF to describe the syndromes caused by various pathogens that can be acquired and transmitted through sexual activity.

† Regardless of condom use during exposure.

§ Commercially available NAATs have not been cleared by FDA for these indications, but they can be used by laboratories that have met all regulatory requirements for an off-label procedure. Source: CDC. Recommendations for the laboratory-based detection of *Chlamydia trachomatis* and *Neisseria gonorrhoeae* — 2014. MMWR Recomm Rep 2014;63(No RR-2):1-19.

¶ The absence of a fourfold or greater titer for a neonate does not exclude congenital syphilis.

** CSF test results obtained during the neonatal period can be difficult to interpret; normal values differ by gestational age and are higher in preterm infants. Values as high as 25 white blood cells (WBCs)/mm3 and/or protein of 150 mg/dL might occur among normal neonates; lower values (i.e., 5 WBCs/mm3 and protein of 40 mg/dL) might be considered the upper limits of normal. Other causes of elevated values should be considered when an infant is being evaluated for congenital syphilis.

†† A women treated with a regimen other than recommended in these guidelines should be considered untreated.

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Page last reviewed: June 4, 2015
Page last updated: June 4, 2015
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