Sexual Assault and Abuse and STIs

This is a PDF version of the following document:
Module 1: STD Question Bank
Lesson 25: Sexual Assault and Abuse and STIs

You can always find the most up-to-date version of this document at https://www.std.uw.edu/go/2021-guidelines/sexual-assault-abuse/core-concept/all.

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Table 1. HBV Nonoccupational Postexposure Prophylaxis Following Sexual Assault

Table 1.

HBV Nonoccupational Postexposure Prophylaxis Following Sexual Assault

HBV Status of Sexual Assault Survivor	HBsAg Status of Assailant		
	HBsAg Positive	HBsAg Status Unknown	HBsAg Negative
Unvaccinated	HBIG x 1, and HBV vaccine series (first dose now)	HBV vaccine series (first dose now)	HBV vaccine ser dose now)
Partially vaccinated	HBIG x 1, and complete HBV vaccine series	Complete HBV vaccine series (give next dose in series now)	Complete HBV v series (give next series now)
Fully vaccinated but response to vaccine unknown	HBV vaccine booster dose x 1 (give dose now)	HBV vaccine booster dose x 1 (give dose now)	No treatment
Fully vaccinated with documented response to vaccine*	No treatment	No treatment	No treatment
Vaccine nonresponder^	HBIG x 2 (separated by 1 month)	HBIG x 2 (separated by 1 month)	No treatment

Abbreviations: HBV = hepatitis B virus; HBsAg = hepatitis B surface antigen; HBIG = hepatitis B immune globulin
*HBV vaccine responder is defined as a person with anti-HBs ≥10 mIU/mL after completing the HBV vaccine series.
^HBV vaccine nonresponder is defined as a person with anti-HBs <10 mIU/mL after ≥6 doses of HBV vaccine.

Source:

- Tanner MR, O'Shea JG, Byrd KM, et al. Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV - CDC Recommendations, United States, 2025. MMWR Recomm Rep. 2025;74:1-56. [PubMed Abstract]
- Workowski KA, Bachmann LH, Chan PA, et al. Sexually transmitted infections treatment guidelines, 2021. Sexual assault and abuse and STIs: adolescents and adults. MMWR Recomm Rep. 2021;70(No. RR-4):1-187. [2021 STI Treatment Guidelines]

Table 1. 2021 STI Treatment Guidelines: Sexual Assault
Empiric Antimicrobial Treatment after Sexual Assault

Recommended Regimen for Adolescent and Adult Female Sexual Assault Survivors

Ceftriaxone *500 mg* IM in single dose*	+	**Doxycycline** *100 mg orally twice daily for 7 days^*	+	**Metronidazole** *500 mg orally twice daily for 7 days*

^For pregnant women, oral azithromycin 1 gram in a single dose is recommended to treat chlamydia in place of doxycycline.
Note: *For persons weighing ≥150 kg, 1 g of ceftriaxone should be administered.

Recommended Regimen for Adolescent and Adult Male Sexual Assault Survivors

Ceftriaxone *500 mg* IM in single dose*	+	**Doxycycline** *100 mg orally twice daily for 7 days*

Note: *For persons weighing ≥150 kg, 1 g of ceftriaxone should be administered.

Source: Workowski KA, Bachmann LH, Chan PA, et al. Sexually transmitted infections treatment guidelines, 2021. Sexual assault and abuse and STIs. MMWR Recomm Rep. 2021;70(No. RR-4):1-187. [2021 STI Treatment Guidelines]

Table 2. Estimated Per Act Risk for Acquiring HIV from an Infected Source, by Exposure Act

Table 2.

Estimated Per-Act Probability of Acquiring HIV from a Source with HIV, by Exposure Act*

Exposure Type	Rate for HIV Acquisition per 10,000 Exposures
Parenteral	
Blood transfusion	9,250
Needle sharing during injection drug use	63
Percutaneous (needlestick)	23
Sexual	
Receptive anal intercourse	138
Insertive anal intercourse	11
Receptive penile-vaginal intercourse	8
Insertive penile-vaginal intercourse	4
Receptive oral intercourse	Low
Insertive oral intercourse	Low
Other^	
Biting	Negligible
Spitting	Negligible
Throwing body fluids (including semen or saliva)	Negligible
Sharing sex toys	Negligible

*Factors that may increase the risk of HIV transmission include sexually transmitted diseases, acute and late-stage HIV infection, and high viral load. Factors that may decrease the risk include condom use, male circumcision, antiretroviral treatment, and preexposure prophylaxis. None of these factors are accounted for in the estimates presented in the table.
^HIV transmission through these exposure routes is technically possible but unlikely and not well documented.

Source:

- Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Updated Guidelines for Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, and Other Nonoccupational Exposure to HIV – United States, 2016. [CDC]
- Patel P, Borkowf CB, Brooks JT, Lasry A, Lansky A, Mermin J. Estimating per-act HIV transmission risk: a systematic review. AIDS. 2014;28:1509-19. [PubMed Abstract]

Table 3. HIV Nonoccupational PEP for Adults, Adolescents, and Pregnant Women

2025 CDC Recommendations for Nonoccupational Postexposure Prophylaxis after Exposure to HIV **Preferred and Alternative Regimens for HIV Nonoccupational PEP in Adults and Adolescents***	
Adults and Adolescents Aged ≥12 years (with creatinine clearance ≥50 mL/min)	
Preferred	**Integrase Strand Transfer Inhibitor PLUS Two Nucleoside Reverse Transcriptase Inhibitors** • Bictegravir-tenofovir alafenamide-emtricitabine • Dolutegravir PLUS (tenofovir alafenamide OR tenofovir DF) PLUS (emtricitabine OR lamivudine)
Alternative	**Boosted Protease Inhibitor PLUS Two Nucleoside Reverse Transcriptase Inhibitors** • (Darunavir-cobicistat OR Darunavir and ritonavir) PLUS (tenofovir alafenamide OR tenofovir DF)
Pregnant Women (with creatinine clearance ≥50 mL/min)	
Preferred	**Integrase Strand Transfer Inhibitor PLUS Two Nucleoside Reverse Transcriptase Inhibitors** • Bictegravir-tenofovir alafenamide-emtricitabine • Dolutegravir PLUS (tenofovir alafenamide OR tenofovir DF) PLUS (emtricitabine OR lamivudine)
Alternative	**Boosted Protease Inhibitor PLUS Two Nucleoside Reverse Transcriptase Inhibitors** • Darunavir and ritonavir (twice daily) PLUS (tenofovir alafenamide OR tenofovir DF) PLUS (emtric
*The regimens within categories are listed in alphabetical order and not to preference.	

Source:

- Tanner MR, O'Shea JG, Byrd KM, et al. Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV - CDC Recommendations, United States, 2025. MMWR Recomm Rep. 2025;74:1-56. [PubMed Abstract]

Table 4. Recommended Laboratory Monitoring of Source Persons and Exposed Persons Following Nonoccupational Exposure to HIV

Table 4.

HIV Nonoccupational PEP: Recommended Laboratory Monitoring of Source and Exposed Persons

Test	Source	Exposed			
	Baseline	Baseline		4-6 Weeks after exposure	12 weeks
		All persons evaluated for n			
Rapid (point-of-care) or laboratory-based HIV Ag/Ab test)[†]	√	√	√[§]	√	—
HIV diagnostic NAT[¶]	√[**]	√[**]	√[§]	√	—
HBV serology, including: HBsAg, HBsAb, and HBcAb	√	√[††]	—	—	If HBV nonimmune at baseline
HCV antibody testing	—	√[§§]	—	—	If follow-up testing recommended[¶¶]
HCV RNA NAT	√[***]	—	If follow-up testing recommended[†††]	—	—
Syphilis serology[§§§]	√	√	√[§§§]	√[§§§]	—
Gonorrhea NAAT[****]	√	√	—	—	—
Chlamydia NAAT[****]	√	√	—	—	—
Pregnancy test[††††]	—	√	√	—	—
		All persons considered for			
Serum creatinine		√		Only if abnormalities at baseline	
Alanine aminotransferase and aspartate aminotransferase		√		Only if abnormalities at baseline or symptomatic	

Abbreviations: Ag/Ab = antigen/antibody combination test; ARV = antiretroviral; HBcAb = hepatitis B core antibody; surface antigen; HBV= hepatitis B virus; HCV = hepatitis C virus; NAT = nucleic acid test; NAAT = nucleic acid ampl prophylaxis; PEP = postexposure prophylaxis; STI = sexually transmitted infection.

*Any person diagnosed with an infection or condition through testing should be informed and treated or referred for
[†]If a rapid (point-of-care) HIV Ag/Ab test is used, a laboratory-based HIV Ag/Ab test obtained at the same time will in awaiting laboratory results. If the preferred HIV diagnostic test is not accessible, the most sensitive available test sh
[§]HIV testing 4–6 weeks post-nPEP initiation can be deferred for persons who started nPEP within 24 hours of exposur this time.
[¶]NATs that detect HIV RNA include qualitative tests for diagnosis (e.g., HIV-1 RNA assay) and quantitative tests for d recommended because they are more likely than viral load tests to detect very low levels of HIV. If the preferred HI test should be used; inability to access HIV NAT should not prevent provision of HIV nPEP to persons with indications
**HIV NAT recommended at baseline assessment for persons with injectable ARV exposure during the past 6 month
[††]HBV PEP recommendations vary by the exposed person's HBV immune status, and by the source's HBV status (wh
[§§]Reflex to HCV RNA NAT if HCV antibody test is positive. Add HCV RNA NAT to original order if signs and symptoms elevation).

Test	Source	Exposed		
	Baseline	Baseline	4-6 Weeks after exposure	12 weeks
		All persons evaluated for		

¶¶If follow-up testing is recommended based on the source's status (e.g., HCV RNA positive or HCV antibody test is p
is unknown), and HCV RNA NAT is negative 3–6 weeks postexposure, a final test for HCV antibodies 4–6 months pos
***HCV RNA NAT is preferred for testing of the source, but if not accessible, HCV antibody testing with reflex HCV RI
††If follow-up testing is recommended based on the source's status (e.g., HCV RNA positive or positive HCV antibody
unknown), HCV RNA NAT is recommended for the exposed persons 3–6 weeks postexposure.
¶¶¶If initial syphilis testing negative and infection in the source cannot be ruled out, follow-up testing may be perforr
****NAATs are recommended for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* at exposure sites (e.g., pharynx
weeks postexposure if no presumptive treatment was provided and initial test results were negative. Repeat testing
for STIs. Certain experts would also perform a NAAT for *Trichomonas vaginalis* from a urine or vaginal specimen for
††††For all women of child-bearing potential who are not known to be pregnant.

Source:

- Tanner MR, O'Shea JG, Byrd KM, et al. Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV - CDC Recommendations, United States, 2025. MMWR Recomm Rep. 2025;74:1-56. [PubMed Abstract]

Table 5. Testing for Victim and Assailant

Table 5.

Baseline Laboratory Testing

Laboratory Test	Sexual Assault Survivor	Alleged Assailant
Hepatitis B surface antibody (anti-HBs)	Negative	Negative
Hepatitis B surface antigen (HBsAg)	Negative	Positive
Hepatitis B core antibody (anti-HBc)	Negative	Positive
Hepatitis C antibody	Negative	Negative
HIV-1/2 antigen-antibody	Negative	Negative

Table 6. Potential HBV Serologic Results and Recommended Course of Action

Table 6.

Baseline HBV Serologic Results

HBsAg	anti-HBs	anti-HBc	Interpretation	Recommended Action
(+)	(-)	(+)	Chronic HBV infection	Link to care for HBV treatment
(+)	(-)	IgM (+)	Acute HBV infection	Link to care for management and follow-up
(-)	(+)	(+)	Resolved HBV infection	Reassurance
(-)	(+)	(-)	Immune to HBV	Reassurance
(-)	(-)	(-)	Susceptible to HBV (non immune)	Vaccinate
(-)	(-)	(+)	"Isolated anti-HBc" may represent (1) prior HBV infection, (2) a false-positive test, (3) occult HBV infection, or (4) window phase of acute HBV infection	Expert consultation advised to determing optional further evaluation and management.

Abbreviations: HBV= hepatitis B Virus; HbsAg = hepatitis B surface antigen; anti-HBs = hepatitis B surface antibody; anti-HBc = hepatitis B core antibody

Table 7. Implications of Diagnosis of Sexually Transmitted Infections and Reporting in Prepubertal Children and Infants

Table 7.

Implications of Diagnosis of Sexually Transmitted Infections and Reporting in Prepubertal Children and Infants

Sexually Transmitted Infection	Sexual Abuse	Suggested Action
Chlamydia trachomatis	Diagnostic*	Report
Neisseria gonorrhoeae	Diagnostic*	Report
HIV	Diagnostic**	Report
Syphilis	Diagnostic*	Report
Trichomonas vaginalis	Highly suspicious	Report
Anogenital warts	Suspicious*	Report
Herpes simplex virus (genital location)	Suspicious^	Report
Bacterial vaginosis	Inconclusive	Medical follow-up

*If not acquired perinatally and rare, nonsexual vertical transmission can be excluded.
**If not acquired perinatally, through breastfeeding, or transfusion.
^Autoinoculation should be excluded.
Adapted from: Kellogg N. The evaluation of sexual abuse in children. Pediatrics. 2005;116:506-12.

Source:

- Kellogg N. The evaluation of sexual abuse in children. Pediatrics. 2005;116:506-12. [PubMed Abstract]