

## Sexual Assault and Abuse and STIs

This is a PDF version of the following document:

Module 1: STD Ouestion Bank

Lesson 25: Sexual Assault and Abuse and STIs

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#### Table 1.

## HBV Nonoccupational Postexposure Prophylaxis Following Sexual Assault

HBV Status of Sexual	HBsAg Status of Assailant							
Assault Survivor	HBsAg Positive	HBsAg Status Unknown	HBsAg Neg	ative				
Unvaccinated	HBIG x 1, and HBV vaccine series (first dose now)	HBV vaccine series (first dose now)	HBV vaccir dose now)					
Partially vaccinated	HBIG x 1, and complete HBV vaccine series	Complete HBV vaccine series (give next dose in series now)	Complete series (given series now	e next				
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 treatme	ent				
Fully vaccinated with documented response to vaccine*	No treatment	No treatment	No treatme	ent				
Vaccine nonresponder^	HBIG x 2 (separated by 1 month)	HBIG x 2 (separated by 1 month)	No treatme	ent				

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  $\geq$ 10 mIU/mL after completing the HBV vaccine series.  $\hat{}$  HBV vaccine nonresponder is defined as a person with anti-HBs <10 mIU/mL after  $\geq$ 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]
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# 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 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				

<sup>\*</sup>Factors that may increase the risk of HIV transmission include sexually transmitted diseases, acute and latestage 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.

### 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]

<sup>^</sup>HIV transmission through these exposure routes is technically possible but unlikely and not well documented.



## Table 3. 2025 CDC Recommendations for Nonoccupational Postexposure Prophylaxis after Exposure to HIV

Preferred and Alternative Regimens for HIV Nonoccupational PEP in Adults and Adolescents\*

		i
Adults and	l Adolescents Aged ≥12 years (with creatinine clearance ≥50 mL/min)	
Preferred	Integrase Strand Transfer Inhibitor PLUS Two Nucleoside Reverse Transcriptase Inhibi	itors
	Bictegravir-tenofovir alafenamide-emtricitabine	
	<ul> <li>Dolutegravir PLUS (tenofovir alafenamide OR tenofovir DF) PLUS (emtricitabine OR lamivu</li> </ul>	idine)
Alternativ	Boosted Protease Inhibitor PLUS Two Nucleoside Reverse Transcriptase Inhibitors	
e		
	<ul> <li>(Darunavir-cobicistat OR Darunavir and ritonavir) PLUS (tenofovir alafenamide OR tenofov</li> </ul>	/ir DF)
<b>Pregnant V</b>	Women (with creatinine clearance ≥50 mL/min)	
Preferred	Integrase Strand Transfer Inhibitor PLUS Two Nucleoside Reverse Transcriptase Inhibit	tors
	Bictegravir-tenofovir alafenamide-emtricitabine	
	<ul> <li>Dolutegravir PLUS (tenofovir alafenamide OR tenofovir DF) PLUS (emtricitabine OR lamivu</li> </ul>	idine)
Alternativ	Boosted Protease Inhibitor PLUS Two Nucleoside Reverse Transcriptase Inhibitors	
le		

#### 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]

\*The regimens within categories are listed in alphabetical order and not to preference.

• Darunavir and ritonavir (twice daily) PLUS (tenofovir alafenamide OR tenofovir DF) PLUS (emtric



aminotransferase

#### Table 4.

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

Test	Source		Exp	posed		
	Baseli ne	Baselir	ne 4-6	·6 Weeks after e	exposure	12 wee
				All pe	ersons eval	uated fo
Rapid (point-of-care) or laboratory-based HIV Ag/Ab test) <sup>†</sup>	V	V	√§		_	
HIV diagnostic NAT <sup>¶</sup>	√**	√**	√§	√	_	-
HBV serology, including: HBsAg, HBsAb, and HBcAb	V	√ <sup>††</sup>	_	_	If HE nonimm basel	une at
HCV antibody testing	_	√ <sup>§§</sup>	_	_	If follow testi r e commer	ing
HCV RNA NAT	<b>√</b> ***	_	If follow-up testing r e commended	<del>_</del>	_	
Syphilis serology §§§		√	√§§§			-
Gonorrhea NAAT****		√				-
Chlamydia NAAT****		√	_			-
Pregnancy test <sup>††††</sup>	_	√	√			-
				All perso	ons consid	dered fo
Serum creatinine	V	,	Only if abn	normalities seline		
Alanine aminotransferase and aspartate	√	/	Only if abn	ormalities	at	

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.

baseline or symptomatic

\*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 should be also supposed this time.

§HIV testing 4–6 weeks post-nPEP initiation can be deferred for persons who started nPEP within 24 hours of exposult this time.

NATs that detect HIV RNA include qualitative tests for diagnosis (e.g., HIV-1 RNA assay) and quantitative tests for commended 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 (while source if signs and symptoms allowed the source if signs and symptoms elevation).

<sup>¶¶</sup>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



Test	Source		Exposed	
	Baseli ne	Baseline	4-6 Weeks after exposure	12 weeks
			All persons eva	luated for i

\*\*\*HCV RNA NAT is preferred for testing of the source, but if not accessible, HCV antibody testing with reflex HCV RI

the 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.

In the source cannot be ruled out, follow-up testing may be perform \*\*\*\*NAATs are recommended for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* at exposure sites (e.g., pharyna 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 the strength of the strength of

#### 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. **Baseline Laboratory Testing** Laboratory Test Sexual Assault Survivor Alleged Assailant Hepatitis B surface antibody (anti-Negative Negative HBs) 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.

## **Baseline HBV Serologic Results**

HBsAg	anti-ŀ	HBs	anti-HBc		Interpretation		Recommended Action		
(+)	-	(-)		(+)			onic HBV ection	1	to care for HBV tment
(+)		(-)		IgM	(+)	Acu	ite HBV infection	mar	to care for nagement and w-up
(-)		(+)		(+)			solved HBV ection	Rea	ssurance
(-)		(+)		(-)		lmr	nune to HBV	Rea	ssurance
(-)		(-)		(-)			sceptible to HBV n immune)	Vac	cinate
(-)		(-)		(+)		may price (2) test infe win	plated anti-HBc" y represent (1) or HBV infection, a false-positive t, (3) occult HBV ection, or (4) dow phase of tte HBV infection	adv opti eva	ert consultation ised to determing onal further uation and nagement.

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

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

<sup>\*</sup>If not acquired perinatally and rare, nonsexual vertical transmission can 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]

<sup>\*\*</sup>If not acquired perinatally, through breastfeeding, or transfusion.

<sup>^</sup>Autoinoculation should be excluded.

