mount, especially in settings where culture and wet mount of vaginal swab specimens are not obtainable. Data regarding use of NAATs for detection of *T. vaginalis* among children are limited; however, no evidence indicates that performance of NAAT for detection of *T. vaginalis* for children would differ from that for adults. Consultation with an expert is necessary before using NAAT in this context to ensure correct interpretation of results. Because of the implications of a diagnosis of *T. vaginalis* infection in a child, only CLIA-validated, FDA-cleared NAATs should be used (*837*). POC tests for *T. vaginalis* have not been validated for prepubertal children and should not be used. In the case of a positive specimen, the result should be confirmed either by retesting the original specimen or obtaining another. Because of the overall low prevalence of *T. vaginalis* among children, false-positive results can occur, and all specimens that are initially positive should be confirmed.

- HSV can be indicative of sexual abuse; therefore, specimens should be obtained from all vesicular or ulcerative genital or perianal lesions and sent for NAAT or viral culture.
- Wet mount can be used for a vaginal swab specimen for BV if discharge is present.
- Collection of serum samples should 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 for a child acquiring an STI 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 the incidence of most STIs among children is low after abuse or assault, prepubertal girls appear to be at lower risk for ascending infection than adolescent or adult women, and regular follow-up of children usually can be ensured. However, certain children or their parent or guardian might be concerned about the possibility of infection with an STI, even if the health care provider has perceived the risk to be low. Such concerns might be an indication for presumptive treatment in certain settings and might be considered after all relevant specimens for diagnostic tests have been collected.

Other Management Considerations

Children who are survivors of sexual assault or abuse are at increased risk for future unsafe sexual practices that have been linked to higher risk for HPV acquisition (*1426*,*1453*) and are more likely to engage in these behaviors at an earlier age; therefore, ACIP recommends vaccination of these children at age ≥9 years if they have not initiated or completed HPV vaccination (see Human Papillomavirus Infections, Prevention) (https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hpv.html). Although HPV vaccine will not protect against progression of infection already acquired or promote clearance of the infection, the vaccine protects against HPV 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 performed at the initial visit, a complete examination can be scheduled approximately 2 weeks after the last exposure to identify any evidence of STIs. In circumstances in which transmission of syphilis, HIV, HBV, 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 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 should be interpreted carefully because HBV can be transmitted nonsexually. Decisions regarding which tests should be performed should be made on a case-by-case basis.

Risk for Acquiring HIV Infection

HIV has been reported among children for whom sexual abuse was the only known risk factor. Serologic testing for HIV should be considered for sexually abused children. The decision to test for HIV should involve the family, if possible, and be made on a case-by-case basis depending on the likelihood of infection in the assailant (*1448*,*1454*). Although data are insufficient concerning the efficacy of PEP among children, treatment is well tolerated by infants and children with and without HIV, and children have a minimal risk for serious adverse reactions because of the short period recommended for prophylaxis (*1455*).

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

Providers should do the following:

- Review local HIV epidemiology, assess risk for HIV in the assailant, and test for HIV.

- Evaluate the circumstances of the assault or abuse that might affect risk for HIV transmission.
- Perform HIV antigen or antibody testing (or antibody testing, if antigen or antibody testing is unavailable) during the original assessment and again at follow-up visits, in accordance with CDC guidelines (https://stacks.cdc.gov/view/cdc/38856). In considering whether to offer PEP, health care providers should consider whether the child can be treated soon after the sexual exposure (i.e., <72 hours), the likelihood that the assailant has HIV infection, and the likelihood of high compliance with the prophylactic regimen (*1436*). Potential benefit of treating a sexually abused child should be weighed against the risk for adverse reactions.
- Consult with a provider specializing in evaluating or treating children with HIV infection to determine age-appropriate dosing and regimens and baseline laboratory testing, if PEP is being considered.
- Discuss PEP with the caregivers, including its toxicity, unknown efficacy, and possible benefits, for children determined to be at risk for HIV transmission from the assault or abuse.
- Provided adequate doses of medication, if PEP is begun, to last until the follow-up visit 3–7 days after the initial assessment, at which time the child should be reevaluated and tolerance of medication assessed (*139*).

Conflicts of Interest

All authors have completed and submitted the International Committee of Medical Journal Editors form for disclosure of potential conflicts of interest. Christina Muzny reports other support from CDC, during the conduct of the study; grants from the National Institutes of Health/National Institute of Allergy and Infectious Diseases and Lupin Pharmaceuticals; personal fees from Lupin Pharmaceuticals, PhagoMed, Cepheid, and Beckton Dickinson; and personal fees and other support from Roche Diagnostics, Abbott Molecular, and BioFire Diagnostics, outside the submitted work. Hilary Reno reports grants from Hologic, outside the submitted work. Christine Johnston reports other support from CDC, during the conduct of the study; received research funding from Sanofi-Pasteur; royalties from UpToDate; and personal fees from MedPace, Gilead, AbbVie, and UpToDate, outside the submitted work.

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