Sexually transmissible infection (STI) screening tests and risk management post child and adolescent sexual assault

Testing and management for STI risk should be considered according to the timeline below:

1. At baseline (usually when patient is seen following recent sexual assault).
   - Urine PCR for chlamydia, gonorrhoea, trichomonas
   - Hepatitis B serology
   - +/- Hepatitis C serology
   - Syphilis serology
   - HIV serology

   Consider administering Hep B booster vaccine unless the child recently had Hep B vaccination. Consider Hep B immunoglobulin (together with Hep B booster vaccine) if child is not immunised against Hep B and the source is Hep B positive.
   Consider Azithromycin 1 g stat as prophylaxis against chlamydia.
   Consider additional prophylactic antibiotic/s if at risk of (Azithromycin-resistant) gonorrhoea. IM ceftriaxone stat dose see Australian STI management guidelines at https://sti.guidelines.org.au/
   Consider HIV PEP if receptive penile-anal penetration and perpetrator is HIV positive with detectable viral load or 'high risk'. (see ashm June 2023 PEP guidelines at https://pepguidelines1.wpenginepowered.com/guidelines/pep-in-specific-populations/children-younger-than-16-years-of-age/) and consider use of PrEP.
   Consider sexual health counselling and referral for ongoing sexual health care.

2. Testing at 2 to 4 weeks after sexual assault (Consider Pregnancy test).
   - Urine PCR for chlamydia, gonorrhoea, trichomonas
   - Hepatitis B serology
   - +/- Hepatitis C serology
   - Syphilis serology
   - HIV serology

3. Testing at 3 months after sexual assault
   - +/- Hepatitis C serology
   - HIV serology

Note: Testing at 6 months for HIV is no longer recommended.

Note: Hep C prevalence is decreasing. Consider risk profile when deciding to test.