Tayside Sexual & Reproductive Health Service (TSRHS)
Guidance regarding immediate medical care post sexual assault

Pregnancy prevention: emergency contraception

A copper IUD (intrauterine device) is the most effective method of emergency contraception. An emergency "coil" (IUD) is effective up to 120 hours (5 days) after unprotected vaginal sex or up to day 5 after the earliest likely day of ovulation (whichever is later) (shortest length of cycle – 14 days) (e.g., up to day 19 of a regular 28-day cycle: 28-14 + 5= 19).

An IUD insertion can be arranged by contacting the TSRHS nurse in charge (central telephone line: 01382 425542 option 4). Please give the patient oral emergency contraception in any case, even if referring her for the insertion of an emergency coil in case she does not make it to the appointment, or the insertion is not successful.

The Ulipristal Acetate (EllaOne®) emergency pill should be first line oral emergency contraception after a sexual assault unless contraindicated as it is more effective in preventing a pregnancy than the Levonorgestrel (Upostelle ® Emerres Una®) emergency pill. It can be given up to 120 hours (five days) after the sexual assault.

If Ulipristal Acetate is contraindicated (but not Levonorgestrel): Levonorgestrel (Upostelle®) is licensed for use up to 72 hours (three days) but can be given unlicensed up to 120 hours (five days) after unprotected vaginal sex. Remember to give a double dose of the Levonorgestrel emergency pill (3 mg) to women weighing >70 kg or with a BMI >26 kg/m^2.

Please remember: there is a pregnancy risk even if the patient is currently having her menstrual period. If there is any doubt assume a pregnancy risk. Please do a pregnancy test before giving EC

Eligibility for different methods of emergency contraception:

Clinical scenario	Cu-IUD	UPA-EC (EllaOne®)	LNG -EC (Upostelle®/ Emerres Una®)
Single episode of UPSI within 72 hours	✓	✓	✓
Single episode of UPSI between 72 and 120 hours	✓	✓	✓ (unlicensed: FSRH supports up to 120 hours if no other method appropriate)
Multiple episodes of UPSI within 120 hours	✓	✓	✓
Multiple episodes of UPSI occurred under 5 and over 5 days ago (PT negative)	+/- (only if presents within 5 days of earliest estimated time of ovulation)	✓	✓
Using enzyme inducing drugs	✓	X	✓ (double dose recommended 3 mg- unlicensed)
Weight >70 kg or with a BMI >26 kg/m^2	✓	✓	✓ (double dose recommended 3 mg- unlicensed)

Clinical scenario	Cu-IUD	UPA-EC (EllaOne®)	LNG -EC (Upostelle®/ Emerres Una®)
Taken hormonal contraception within the past 7 days, or overdue DMPA injection, expired SDI or IUS	✓	X	✓
Breastfeeding	✓ (higher perforation risk)	X (can be given if the woman is willing to express milk for 7 days after taking tablet)	✓
Repeated use of oral EC in the same cycle	+/- (only if all episodes within 5 days of earliest expected time of ovulation)	+/- (UPA-EC can be given repeatedly; avoid in the 7 days after LNG-EC as less effective)	+/- (LNG-EC can be given repeatedly; avoid in the 5 days after UPA-EC as less effective)
Nulliparous woman	✓	✓	✓

Abbreviations:
IUD: copper intrauterine device ("copper coil")
EC: emergency contraception
FSRH: Faculty of Sexual & Reproductive Healthcare (FSRH)
DMPA: depot medroxy-progesterone acetate (DepoProvera®) or SayanaPress®)
IUS; intrauterine system ("hormone coil")
LNG EC: levonorgestrel containing emergency contraception pill
SDI; subdermal contraceptive implant (Nexplanon®)
UPA EC: ulipristal acetate containing emergency contraception pill
UPSI: unprotected sexual intercourse (including sexual assault)

HIV prevention: Post exposure prophylaxis following sexual exposure (PEPSE)

PEPSE is only indicated in those individuals who have had a significant risk of exposure to HIV. Currently the risk of HIV acquisition from a heterosexual sexual assault in the UK is very low. The risk of acquiring HIV following unprotected sex is dependent on whether the sexual contact is known or at high risk of HIV (high HIV prevalence group) and the type of sexual activity involved.

Please refer to the chart below to help identify those who may benefit from PEPSE. High-risk cases in which PEPSE is being considered (i.e., patients presenting within 72 hours of the attack) can be discussed with a GUM Consultant (01382 425533/ 01382 425542/ mobile: 07740937069) within working hours (Monday- Friday: 9 AM- 5PM) or with the on-call Infectious Diseases Consultant out of hours.

Excerpts are taken from "Guidance for Management of BBV Exposure Events in the Community " (June 21) Source: NHS Tayside Staffnet (please refer to the guide for further information)

The source individual should be asked the questions below or when unavailable or unknown the exposed individual should be asked to answer to the best of their knowledge:

Is the source known to have HIV? If the source has HIV, understanding whether they are on treatment and their last viral load helps refine the risk assessment. PEP is recommended if the index case is known to be HIV positive and is not on antiretroviral treatment for more than 6 months with a suppressed viral load within the last 6 months.

If any of the questions below are answered “Yes” then the source is from a HIV high prevalence group:

- Is the source known to have Hepatitis B or Hepatitis C?
- Does the source come from an endemic region (sub-Saharan Africa, Caribbean, and Thailand)?
- Has the source had a sexual partner from or had sex in an endemic region (sub-Saharan Africa, Caribbean, and Thailand)?
- If the source is not from the UK, have they ever injected drugs?
- If the source is male – have they had sex with other men?
- Does the source have a sexual partner known to have HIV?
- Does the source have a current illness compatible with HIV/AIDS?

Indications for HIV post exposure prophylaxis

Using the information gathered the table below outlines when HIV PEP is indicated. This combines the injury, body fluid and the initial assessment of the source’s risk.

	Source HIV status			
	HIV positive		**Unknown HIV-status**	
	Viral load detectable or unknown	**Viral load undetectable ++**	**High prevalence group +**	**Low prevalence group**
Needle, or other sharp item contaminated with fresh, wet blood penetrating skin	Recommend	Not recommended provided viral load last checked less than 6 months ago and person on ART for >6months with good adherence	Generally not Recommended	Not recommended
High risk fluid on to mucous membrane (eye, nose or mouth)	Recommend	Not recommended	Generally not Recommended	Not recommended
Human Bite *	Generally not Recommended	Not recommended	Not recommended	Not recommended
Receptive anal sex without a condom	Recommend	Not recommended Provided viral load last checked less than 6 months ago and person on ART for >6 months with good adherence	Recommend	Not recommended
Insertive anal sex without a condom	Recommend	Not recommended	Consider **	Not recommended
Receptive vaginal sex without a condom	Recommend	Not recommended	Generally not Recommended **	Not recommended
Insertive vaginal sex without a condom	Consider**	Not recommended	Not Recommended	Not recommended
Fellatio with ejaculation without a condom	Not Recommended	Not recommended	Not recommended	Not recommended
Splash of semen into eye	Not recommended	Not recommended	Not recommended	Not recommended
Fellatio without ejaculation without a condom	Not recommended	Not recommended	Not recommended	Not recommended
Cunnilingus	Not recomm	Not recommended	Not recommended	Not mended

Recent guidance has indicated that a human bite is unlikely to transmit HIV. In the context of a source individual with known HIV infection with a suspected HIV viral load of >3.0 log copies/ml, especially with blood in the mouth prior to the bite (for example in association with dentistry) or where there is significant tissue trauma the risk may be greater, and PEP should be prescribed

** Factors that may influence decision making in sexual exposures include Breaches in the mucosal barrier such as genital ulcer disease or anal/vaginal trauma, multiple episodes of exposure e.g., group sex or STI in either partner. These patients require a specialist assessment within Tayside Sexual and Reproductive Health at the earliest opportunity. With further assessment, continuation of HIV PEP may not be required, and this will be discussed with the patient

+ High prevalence groups include – Having sex in, or a partner from, or coming from, a country of high HIV prevalence (>1%) (sub-Saharan Africa, Caribbean, Thailand); A person who injects or has injected drugs; A man who has sex with other men; A current clinical illness compatible with HIV/AIDS; A sexual partner of known HIV infected person with a detectable viral load

++ Viral load undetectable is where the source is known to have HIV, has had a viral load below 200 copies per ml for at least 6 months and this has been checked within the last 6 months, and is adherent to medication

Hepatitis B prevention

Acquisition of Hepatitis B following sexual assault in the UK is exceedingly rare. The UK is a low prevalence country with a carriage rate of 0.1-0.5%. Guidelines recommend that Hepatitis B vaccine may be considered in those who give a history of a sexual assault up to 6 weeks previously, in particular when there was high risk exposure.

Hepatitis B vaccination should be considered in the following circumstances:

- Assailant known to be a Hepatitis B carrier
- Assailant has risk factors (IVDU, men having sex with men, high prevalence area)
- Anal rape
- Trauma and bleeding
- Multiple assailants
- Client wishes to be vaccinated
- Client not known to be immune to Hepatitis B following vaccination

Recommended Vaccination schedules:

Very rapid schedule	At 0,7, 21 days post exposure with a booster at 12 months
Accelerated schedule	At 0,1,2 months post exposure with a booster at 12 months

Engerix B vaccination (1 ml) should be provided if not previously vaccinated.

Hepatitis B Immunoglobulin 500i.u. IM should be considered within 48 hours and no later than 7 days after a known infectious contact and may be given to a non-immune contact after a single unprotected sexual exposure, if the assailant is known or strongly suspected to have Hepatitis B.

Prophylaxis against bacterial infection

In situations where the patient is unable to tolerate the distress of a further examination or agree to referral for testing for STIs and they are felt to be at high risk of having acquired an infection, it may be appropriate to offer prophylactic antibiotics against infection. The disadvantages of prophylaxis need to be covered:

1) We may be giving unnecessary treatment
2) Reinforcing beliefs that they have been infected with an STI
3) Not diagnosing STIs which could have implications for regular partners

These antibiotics should cover for Gonorrhoea, Chlamydia and Trichomoniasis.
Prevalence of Chlamydia infection in the under 25 age group in Tayside is 9.8% and for Gonorrhoea is <1%. Patients should abstain from sex for 7 days after treatment is completed.

Antibiotic Prophylaxis

Gonorrhoea	Ceftriaxone 1G IM or Cefixime 400 mg stat orally (may be provided if an IM injection is contraindicated or refused by the patient)
Chlamydia	Doxycycline 100mg BD x 1 week or Azithromycin 1 G stat and 500 MG daily for the 2 following days
TV	Metronidazole 2G stat orally or 400 mg BD for 5 days

NB. The efficacy of antibiotics regimes in preventing gonorrhoea and Chlamydia infections after sexual assault has not been studied. Patients need to be warned that they are likely to have GI side effects following the above regime due to the significant antibiotic load.

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