Infecciones de Transmisión Sexual y Agresión Sexual

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“Cualquier acto sexual, o intento para obtener sexo usando la coacción, amenazas de daño o la fuerza física, por cualquier persona, independientemente de la relación con la víctima, en cualquier escenario, incluyendo, pero no limitándolo, el trabajo y el hogar”

Guidelines for medico-legal care for victims of sexual violence. WHO 2012

Consecuencias de la violencia sexual

- embarazo no deseado
- aborto inseguro
- Inf de Transmisión Sexual
- Disfunción sexual
- Inf tracto urinario

- equímosis
- abrasiones
- contusiones
- laceraciones
- trauma genital/anal

- desorden de estrés post traumático
- depresión
- ansiedad
- fobia social
- abuso de sustancias
- suicidio

Datos de ITS en agresiones sexuales

- Escasos datos en la literatura
- Gran variabilidad en los estudios en el tiempo desde que ocurre la AS a la toma de muestras
- Dificultad para vincular los resultados con la agresión
- Dificultad para realizar un estudio prospectivo por la gran pérdida en el follow-up

Experiencia en Occidente

- **Estudio unicéntrico. Seattle (USA) Periodo abr 1985- may 1986.**
    - Mujeres con AS. Penetración vaginal no consentida.
    - 335 AS; 204 participaron en estudio
    - Muestras < 72h desde la agresión y en la visita FU a las 2 semanas.
    - ITS relacionada con la agresión
        - Ausencia de ITS en la visita basal
        - ITS detectada en la visita FU
        - No se había realizado tratamiento empírico
    - FU: visita 1: 109 (53%); visita 2: 52 (25%)

Jenny C. Sexually transmitted diseases in victims of rape. NEJM 1990

Experiencia en Occidente

Table 1. Frequency of Sexually Transmitted Diseases in the Victims of Sexual Assault, as Identified at the Initial and Follow-up Medical Visits.

Pathogen or Condition	Initial Visit	Follow-up Visit	
		Detected at initial visit	Not detected at initial visit
	no. with disease/no. tested (%)		
Neisseria gonorrhoeae	13/203 (6.4)	0/105 (0)	3/105 (2.9)
Chlamydia trachomatis	20/198 (10.1)	1/102 (1.0)	1/102 (1.0)
Herpes simplex virus*	4/170 (2.4)	0/74 (0)	0/74 (0)
Cytomegalovirus*	13/170 (7.6)	8/74 (10.8)	3/74 (4.1)
Trichomonas vaginalis	30/204 (14.7)	17/109 (15.6)	10/109 (9.2)
Bacterial vaginosis	70/204 (34.3)	14/109 (12.8)	15/109 (13.8)
Syphilis†	2/199 (1.0)	0/27 (0)	0/47 (0)
HIV	1/123 (0.8)	0/109 (0)	0/52 (0)

*Diagnosed by positive viral culture.

†Diagnosed by positive serologic tests. Both patients had been treated previously for syphilis.

Table 3. Risk of Acquiring a Sexually Transmitted Disease (STD) after a Sexual Assault.*

Pathogen or Condition	No. with STD at Follow-up/No. Tested	Risk (%)
Neisseria gonorrhoeae	3/71	4.2
Chlamydia trachomatis	1/65	1.5
Trichomonas vaginalis	10/81	12.3
Bacterial vaginosis	15/77	19.5

*For the methods used to calculate risks, see the text.

Jenny C. Sexually transmitted diseases in victims of rape. NEJM 1990

Experiencia en Occidente

- **Noruega. Estudio retrospectivo. Periodo 12 años**
  - 412 pacientes incluidas.
  - 8,5% al menos 1 ITS. 6,5% C trachomatis.
  - 91% recibieron profilaxis antibiótica, 19% VHB i 2,9% PEP para VIH.
  - Solo 2 ITS se relacionaron con la AS (no relaciones previas)
- **Francia. Estudio prospectivo. Periodo julio 2012-julio 2013**
  - 326 pacientes incluidos (93,6%) mujeres.
  - C trachomatis 14,7% N gonhorreae 4,9%
  - Tratamiento según resultados
  - No se pudieron relacionar las ITS con la AS.

Haggemann. Sexually Transmitted Infections 2014
Jaureguy. Forensic Science International 2016

Experiencia en Occidente

- **Francia. Estudio prospectivo. Periodo enero-diciembre 2014**
  - 146 pacientes (138 mujeres)
  - 6,3% C trachomatis, 5,5% Mycoplasma genitalium.
  - Sin profilaxis antibiótica
  - Sin datos de relación con la AS.

Fougas. Sexually Transmitted Infections. 2017

- **Estudios ideales de ITS en agresión sexual**
    - Realizar test al **inicio** y en el **follow-up**
    - Tratamiento **antibiótico dirigido** y diferido
    - Recoger información sobre relaciones sexuales consentidas antes del primer test y entre la visita basal y el FU
- **Limitaciones**
    - **Pérdida de seguimiento** en la mayoría de estudios

VIH y agresión sexual

- En general, **baja prevalencia de infección por VIH en la visita inicial** < 2,5%[1]
- Descritos algunos casos en la década de los 90 de seroconversión en la literatura después de una AS (no se realizó profilaxis VIH)[2,3]
- Estudio realizado en H Clinic[4]. Prevalencia **visita basal de 1,1**% (3 de los casos eran no conocidos) -> 1 seroconversión en HSH expuesto tras finalizar PEP.
- La prescripción de la **PEP es muy variable** según los estudios (3-50%) y la **adherencia a los posteriores controles y a la medicación es baja**[5]

[1]Hernandez-Ragpa. EIMC 2018

[2]Claydon E. Rape and HV. Int Journal AIDS and STD 1991

[3]Albert J. J Virol 1994

[4]Inciarte A. HIV Medicine 2019

[5]Ebert J. Forensic Sci Med Pathol 2018

Qué dicen las guías?

Treatment

Compliance with follow-up visits is poor among survivors of sexual assault (*866,867*). As a result, the following routine presumptive treatment after a sexual assault is recommended:

- An empiric antimicrobial regimen for chlamydia, gonorrhea, and trichomonas.
- Emergency contraception. This measure should be considered when the assault could result in pregnancy in the survivor.
- Postexposure hepatitis B vaccination (without HBIG) if the hepatitis status of the assailant is unknown and the survivor has not been previously vaccinated. If the assailant is known to be HBsAg-positive, unvaccinated survivors should receive both hepatitis B vaccine and HBIG. The vaccine and HBIG, if indicated, should be administered to sexual assault survivors at the time of the initial examination, and follow-up doses of vaccine should be administered 1–2 and 4–6 months after the first dose. Survivors who were previously vaccinated but did not receive postvaccination testing should receive a single vaccine booster dose (see hepatitis B).

- HPV vaccination is recommended for female survivors aged 9–26 years and male survivors aged 9–21 years. For MSM with who have not received HPV vaccine or who have been incompletely vaccinated, vaccine can be administered through age 26 years. The vaccine should be administered to sexual assault survivors at the time of the initial examination, and follow-up dose administered at 1–2 months and 6 months after the first dose.

- Recommendations for HIV PEP are individualized according to risk (see Risk for Acquiring HIV Infection and Postexposure HIV Risk Assessment for PEP).

Sexually Transmitted Diseases Treatment Guidelines. Centers for Disease Control and Prvention. 2015

Qué dicen las guías?

Sexual abuse

In any sexual abuse case medical and legal connotations should be taken into account and apply the established protocols.

It is estimated that the risk of HIV sexual transmission might be higher in rape victims with genital and/or anal lacerations produced during the raping. Although there is not much data about the prevalence of HIV infection between people with charges of rape, PEP is recommended in every case it exists. PEP guidelines and starting times should follow the same criteria as in other risk sexual intercourse.

It is recommended to start an empirical antibiotic treatment in sole dose to avoid other STI.

Documento de consenso sobre Profilaxis Post Exposición para VIH, VHB y VHC en adultos y niños. EIMC 2105

Management and Treatment

Considerations for prophylaxis

- Offer prophylaxis if:
  - Unsure that the patient will be returning for follow-up.
  - It is known that the assailant is infected with a specific STI.
  - It is requested by the patient/parent/guardian.
  - The patient has signs or symptoms of an STI.
- In addition, it may be appropriate to routinely offer prophylaxis in situations where vaginal, oral or anal penetration has occurred, because most sexual assault victims do not return for follow-up visits. [8, 13, 14]
- It should be noted that the efficacy of antibiotic prophylaxis has not been studied in sexual assault; prophylaxis should be as recommended for treatment of specific infections (see chapters on specific infections for more information).

Canadian Guidelines on Sexually Transmitted Infections – Specific populations – Sexual assault in postpubertal adolescents and adults. 2013

Qué dicen las guías?

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UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault. Review 2013

11. Prophylaxis of bacterial STI's

Gonorrhoea, Chlamydia and Trichomoniasis are the infections most frequently identified in women who present with a history of sexual assault (43, 44, 45). The peak age for sexual assault is similar to that of many STIs, so their presence does not necessarily indicate acquisition as a result of the assault.

Prophylaxis against STIs can be offered as part of immediate medical aftercare post sexual assault. Using bacterial prophylaxis may reduce the need for tests, decrease the chances of detecting a bacterial STI and lessen the chance of missing an infection in cases of default from follow up. The advantages of bacterial prophylaxis have to be weighed against the disadvantages. These include unnecessary treatment, reinforcing belief that there was a high risk of infection (which in itself may raise levels of anxiety) and missing out on partner notification, if the source of infection was someone other than the assailant, leading to the possibility of re-infection by a regular or known sexual partner (46). In situations where the client may default, is unable to tolerate the distress of a repeat examination or requires an IUD for emergency contraception, prophylactic treatments with antibiotics which cover gonorrhoea and Chlamydia and trichomoniasis may be offered (Table 3). Weigh up the advantages of giving Metronidazole in a stat 2 g oral dose against its potential for causing vomiting (and thus a potential reduction of the efficacy of any emergency oral contraception).

Management

Considerations

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Circuito Programa AS Hospital Clínic

- Consulta en servicio de UCIAS
- Atención multidisciplinar
    - Trabajadora social
    - Enfermera de UCIAS
    - Ginecología/Cirugía
    - Médico Forense
    - Enfermedades Infecciosas
    - Psiquiatría

- UCIAS
    - Analítica con tóxicos
    - Tratamiento empírico ITS
    - Profilaxis PEP. Pack 28 días
- Seguimiento INF
    - Programación analítica < 7 días
    - Contacto telefónico para resultados y valorar tolerancia a la PEP
    - FU a los 2 y 4 meses

Circuito Programa AS Hospital Clínic
Valoración Infecciones

- Tiempo desde la AS hasta la consulta en UCIAS
- Tipo de agresión sexual (penetración anal/vaginal/felación)
- Uso de preservativo
- Características del agresor -si se conocen- (VIH, UDVP, VHB, HSH…)

- ***La intervención va dirigida a***
    - Prevenir ETS (CT, NG, Trichomonas)
    - VIH, VHB, Sífilis

Ceftriaxona 1 gr/im o iv
Azitomicina 1 gr/vo
Metronidazol 2 gr vo/iv
PEP
Vacuna VHB/Gammaglobulina

Conclusiones

- La prevalencia de ITS en víctimas de AS es alta en relación a la población general en estudios realizados en occidente
- La prevalencia de VIH, VHB, VHC y sífilis es baja en la valoración inicial y la tasa de seroconversión es muy baja.
- Alta pérdida de seguimiento en la consulta de INF de las víctimas de AS
- Hacen falta estudios bien diseñados en nuestro entorno para conocer la prevalencia real en víctimas de AS
- Hay que mejorar la adherencia al seguimiento

Gracias