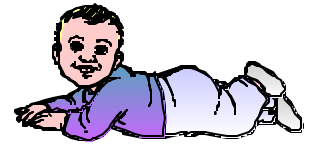




STATE TRAUMA ADVISORY BOARD MANAGEMENT RECOMMENDATIONS



SUBJECT: CHILD ABUSE RECOGNITION & MANAGEMENT

PURPOSE: To facilitate and optimize the recognition and management of children who suffer trauma by neglect and/or intentional physical abuse.

DEFINITIONS / BACKGROUND:

- ! CHILD ABUSE & NEGLECT (CAN): Consists of 4 categories (*neglect, physical abuse, sexual abuse, emotional abuse*)
- ! CHILD NEGLECT: Most common etiology of child maltreatment including physical injury. Includes failure of a caretaker to provide basic shelter, supervision, medical care, or support.
- ! PHYSICAL ABUSE: Infliction of intentional injury through excessive force or forcing a child to engage in physically harmful activity.
- ! SEXUAL ABUSE: Inappropriate exposure of a child to sexual acts or materials, the passive use of children as sexual stimuli for adults and actual sexual contact between children and older people.
- ! CHILD EMOTIONAL ABUSE: Coercive, demeaning, or overly distant behavior by a parent or other caretaker that interferes with a child's normal social or psychological development.
- ! Child abuse (all 4 forms) occurs in **all** social strata.
- ! Most children that have significant morbidity or even mortality from child abuse have had previous visits for injuries and other ill-defined events.
- ! Best estimates are that 2-3% of the population < 18 years of age undergo some maltreatment **each year**.
- ! 1000 – 2000 children die each year in the United States due to abuse (**24 in Oregon in 1998**). 80% childhood deaths due to abuse occur in children < 5 years old and 40% occur in children < one year old.
- ! All 50 states have statutes defining mandatory reporters of “suspected” child abuse (which include all health care providers) and protection from retaliatory lawsuits if unsubstantiated. (ORS 419B.005 to 419B.045)

I. MAINTAINING A HIGH INDEX OF SUSPICION

A. History: High-Risk Characteristics

1. Discrepancy between the history of injury, developmental ability of the child, and the extent of physical injury.
2. Delay interval between time of injury and seeking medical advice.

3. History of repeated trauma, treated in different settings especially with unsubstantiated histories.
4. Parent(s) respond inappropriately (taking into account cultural differences) or do not comply with medical advice. This includes defensive posturing re: inquiries into possible child abuse / neglect issues.
5. The history of injury changes over time or between interviewers (including prehospital personnel) or is inconsistent between parents or other caregivers (including daycare providers and teachers).
6. History of “easy bruising”
7. History of previous abuse and/or neglect, previous involvement of Services for Children & Families (SCF).

B. Physical Exam: High-risk Characteristics

1. Duodenal hematomas are often the result of inflicted injury.
2. Retinal hemorrhages (RHs), outside of the newborn period, (due to birth trauma) are exceedingly rare (even in cases of prolonged CPR) and in non-intentional injuries are due to **rapid** deceleration injuries. The finding of RHs are not pathognomic but *highly suspicious* for inflicted injury.
3. Perioral injuries are frequently due to inflicted trauma including forced feeding.
4. Ruptured internal viscera without known major blunt trauma
5. Trauma to the genital or perianal areas
6. Evidence of frequent injury (old scars or healed fractures)
7. Unusual injuries such as bites, cigarette burns, bruises that resemble hands or other objects, or rope marks
8. Sharply demarcated 2nd and 3rd degree burns in unusual areas
9. Immersion burn patterns: stocking/glove distributions, forced sitting in bathtub (sparing of contact areas)
10. Evidence of sexual abuse. Continuing controversies in the definitive diagnosis of childhood sexual abuse mandates a low threshold to refer to an expert in childhood sexual abuse for evaluation.

11. Congenital skin markings (eg. “Mongolian” spots), congenital or acquired bleeding (eg. Von Willebrands Disease, hemophilia, anticoagulant ingestion, Henoch-Schonlein Purpura) or skeletal disorders (osteogenesis imperfecta) and cultural practices (“coining,” “cupping”) should not be mistaken for inflicted abuse
12. Observing apparent “appropriate” interactions between caretakers and child with a suspicious history and/or physical exam frequently sways clinicians from reporting abuse. This is the most unreliable factor in considering to reporting abuse.

C. Imaging And Laboratory Results: High-Risk Characteristics

1. Skull fractures that are depressed, stellate or multiple with history of low-level falls (< 6 feet)
2. Multiple subdural hematomas (SDH), especially without acute skull fracture. “Spontaneous” SDHs are exceedingly rare in children and the etiology usually readily apparent (AVMs, severe dehydration, or meningitis).
3. Long bone fractures in children younger than three years old
4. Metaphyseal “corner” fractures frequently are due to intentional injury

II. TRANSFER TO HIGHER LEVEL CARE

- A. Use pre-existing acuity-based interhospital transfer criteria. Suspicion of intentional injury increases the risk of occult injuries and should lower the threshold to transfer patient to higher level of care. The need to do an intensive investigation for CAN may also lower the threshold to transfer a patient with potential CAN.
- B. Transferring facility should document suspicion of CAN in the chart and clearly communicate suspicion to the receiving service
- C. Usual stabilization criteria prior to transfer
- D. Reporting of injury to authorities: **as soon as suspicion arises**. This expedites initial investigation including documenting water temperatures and pinning down histories of injuries, making appropriate convictions more likely. The sooner perpetrators are confronted the more likely they will be tripped up or confess.

III. RECEIVING PHYSICIAN/HOSPITAL

- A. For most pediatric traumas requiring transfer: Level I or II accredited Oregon trauma hospital with pediatric intensive care service (Both Level I hospitals have child abuse teams)
- B. For children meeting trauma system entry criteria, transfer should be to receiving facility's trauma service. For others, transfer can be facilitated through pediatric services (PICU, ward service) or Emergency Department. Child abuse teams do not accept patients directly. The trauma service should be consulted for any children with significant injuries on other services.
- C. For children on the trauma service, the role of trauma service is to coordinate care including consulting with CAN specialists to ensure appropriate reports to authorities are made.

IV. FOLLOW-UP DATA

Referring agencies should receive specific feedback re: verified CAN or not and resolution of case

V. RESOURCES

Reece R. (ed). Child Abuse: Medical Diagnosis and Management. Phila.: Lea & Febiger 1994.

AAP. Focus on Child Abuse 2nd ed. (CD-ROM) 1998. (www.aap.org)

AAP. A Guide to References and Resources in Child Abuse and Neglect 2nd ed. (www.aap.org)

Wissow LS. Child abuse and neglect. NEJM 1995;21:1425-1431.