

**CLINICAL PRACTICE RESOURCE
FOR HOSPITALS AND EMERGENCY DEPARTMENTS:
Evaluation and Management of Suspected Child Abuse or Neglect**

I. IDENTIFY THE CHILD WHO MAY BE A VICTIM OF ABUSE OR NEGLECT.

A. Injuries (bruises, burns, fractures) that should be carefully evaluated for *physical abuse*:

1. Age 0-6 months: *Any injury*.
2. Age 6 months or older:
 - a. Bruises, lacerations, or burns to protected, fleshy, or flexor surfaces—for *example*, inner thighs, abdomen, neck, face (other than frontal prominence), pinna, genitalia.
 - b. Bruises, lacerations, or burns showing an object pattern—for *example*, belt loop, cigarette burn, curling iron.
 - c. Oral injuries, *especially* frenulum and palate lacerations
 - d. Third-degree burns or large second-degree burns, *especially* scald burns.
 - e. Fractures, *especially* metaphyseal fractures, complex or wide skull fractures, rib fractures, spiral fractures of humerus or femur, scapula fractures.
 - f. Significant head injury, *especially* subdural hematoma, retinal hemorrhage, subgaleal hematoma, avulsed hair, complex or wide skull fracture. Head injury should be considered whenever a child presents with vomiting or altered consciousness, or bloody spinal fluid is found on lumbar puncture, but an infectious process cannot be readily diagnosed.
 - g. Intraabdominal injury, *especially* rupture or hematoma of internal organ.
3. Age 0-10 years: Positive urine or blood screen for alcohol or drugs of abuse.

B. Findings that should be carefully evaluated for *sexual abuse*:

1. Any injury to the genitalia (*especially* to the hymen or vestibule in girls) or anus.
2. Identification of an STD: Chlamydia, gonorrhea, HSV, HPV, HIV, HBV, HCV, Trichomonas, syphilis.
3. Positive pregnancy test.
4. Any history or statement or witnessed incident consistent with sexual abuse.

C. Findings that should be carefully evaluated for *neglect*:

1. Growth parameters below expected for age.
2. Lack of medical care for a significant health problem—for *example*, no medications for asthma, diabetes; no care of severe dental caries.
3. Lack of normal bonding with parent/guardian.
4. Disregard of one or more basic child care needs—for *example*, soft drink in baby bottle, child found in street, failure to place child in auto safety seat or belt.

Note: A child may have findings suggesting more than one form of abuse or neglect.

II. CONSIDER THE EXPLANATION GIVEN BY THE PARENT/GUARDIAN OR CHILD.

A. Possible *physical abuse*.

1. Does the parent/guardian or child give a *logical explanation* that is consistent with the age, pattern, and severity of the injury?
 - a. Consider developmental level of child. Is the child capable of the alleged action? *For example*—a 6-month-old cannot unbuckle a car seat.
 - b. Consider biomechanics of injury. *For example*--a fall from less than 4 feet rarely causes a fracture and almost never causes intracranial hemorrhage; a child who cannot crawl or walk cannot self-inflict a bruise, fracture, burn, or laceration.

B. Possible *sexual abuse*.

1. Does the parent/guardian or child give a *logical explanation* that is consistent with the examination findings? *For example*--in a child with venereal warts, is there documentation of maternal HPV infection during pregnancy or delivery?

C. Possible *child neglect*.

1. Does the parent/guardian give a *reasonable explanation* that is consistent with the pattern and severity of the findings suggesting neglect (and can he/she provide documentation)? *For example*—has a child who is small for age been worked up for medical or familial causes of short stature/failure to thrive?

III. WORKUP AND INITIAL MEDICAL MANAGEMENT

A. In ALL cases of suspected abuse or neglect.

1. Report case to Children's Protective Services (statewide number: 1-800-252-5400).

Have readily at hand as much of the following as possible:

- the facts of the case,
 - the child's and parents' home address, phone numbers, dates of birth, social security numbers
 - siblings' names, ages, and whereabouts
2. Consult hospital Social Worker. *NOTE: Social Workers may assist in reporting cases of suspected abuse to CPS or law enforcement, but the clinician who recognizes the suspected abuse has the ultimate legal responsibility to make certain the report is made.*
 3. Complete appropriate Child Abuse/Neglect protocol form(s) (*Attachments #1 and 2 are protocol forms developed by the Texas Pediatric Society Committee on Child Abuse and Neglect, that clinicians are free to use and reproduce.*) and attach to medical record. Forward copies to hospital's multidisciplinary child protection team, if applicable.
 4. Photograph visible injuries if possible, *and* carefully diagram all positive exam findings.
 5. Attempt to obtain parent/guardian consent for treatment, procedures, and photographs. *However, consent is not necessary if it is refused. The Texas*

Family Code (§32.005, rev. 7/17/2000) permits a physician to examine a child under age 16 when abuse or neglect is suspected, if necessary without the consent of the parent, guardian, or child. "Examination" may include X-rays, blood tests, and photographs.

6. Consult local or regional forensic child abuse specialist, especially in complex, uncertain, or high-profile cases.
7. *Do not discharge child if a potential perpetrator may have access to him/her until CPS has made a disposition. Consider admission to the hospital if necessary.*
8. Arrange or recommend to parent/guardian or CPS that any siblings or other children in the household be examined as soon as possible.
9. Inquire whether any adult in the household is a victim of domestic violence, and refer for services if necessary.
10. In cases of clear criminal activity or where CPS does not have authority to investigate, notify the law enforcement agency *where the abuse probably occurred.*
11. Contact Hospital Security and/or local police department if there is imminent risk of violence or other criminal activity on hospital premises, or if there is a risk that the parent may attempt to leave the hospital with the child.

B. Suspected *physical abuse.*

1. Age 0-2 years: skeletal survey in all cases (*not* long bone series or "babygram").
2. Age 2-5 years: skeletal survey should be considered (*not* long bone series or "babygram").
3. Nuclear medicine bone scan (or repeat skeletal survey in 2 weeks) if index of suspicion for skeletal injury remains high despite negative initial skeletal survey (*for example--* in cases of Shaken Baby Syndrome).
4. CT scan of head if suspected acute intracranial injury; MRI scan of head if subacute (older than 5 to 7 days) or chronic intracranial injury.
5. CT scan of abdomen if suspected serious blunt thoracoabdominal trauma.
6. For detailed imaging standards and protocols, consult the listed reference from the American Academy of Pediatrics Section on Radiology.
7. CBC, platelet count, International Normalizing Ratio (INR) or prothrombin time (PT), partial thromboplastin time (APTT), and bleeding time if large bruises are present.
8. Serum liver transferase (AST/ALT), amylase, and lipase levels if abdominal trauma is suspected or present.
9. Ophthalmology consult for thorough fundoscopy in cases of:
 - Suspected intracranial injury;
 - Suspected Shaken Infant Syndrome (metaphyseal fractures, subdural/subarachnoid hemorrhage, and/or posterior rib fractures).
 - Spiral fracture, metaphyseal fracture, or other injury in child under age 2 suggestive of shaking or twisting injury.
 - Fracture in infant under age 6 months.

C. Suspected sexual abuse.

1. Complete physical examination.
2. Age 0-2 years: skeletal survey in all cases with visible acute injuries.
3. Age 2-5 years: skeletal survey should be considered if visible acute injuries.
4. *For non-acute sexual abuse allegations:* if a sexual abuse examination center (e.g., Children's Advocacy Center) is located nearby, a child may be referred to that center in lieu of receiving a detailed sexual abuse examination in Emergency Department/Inpatient Unit *if* that center agrees to the referral, and *if* the child and/or parent/guardian agree to the referral.
5. Careful inspection of external genitalia and anus for evidence of trauma, in exam setting with adequate lighting, positioning, and magnification.
 - Position child in frog-leg supine position; adolescent male in supine position for genitalia and decubitus position for anus exam; adolescent female supine in stirrups.
 - In girls, use labial traction technique to visualize vestibule and hymen. Also inspect labia majora, perineum, inner thighs, lower abdomen.
 - In girls, position in the prone knee-chest position to confirm suspected abnormal hymenal or vestibular findings.
 - In boys, careful inspection of penis, scrotum, perineum, inner thighs, lower abdomen.
 - In both sexes, careful inspection of anus and perianal area for evidence of trauma. Use gentle gluteal separation to inspect anal rugae and outer canal.
6. If the history suggests the child had genital, anal, or oral contact with the perpetrator's genitalia, if there is evidence of genital, anal, or oral trauma, or if genital or anal discharge, testing for sexually transmitted diseases should be performed:
 - Cultures (*not DNA probes or other screening tests*) of: throat; vagina (in prepubertal or young teen girls), cervix (in postpubertal girls), or male urethra, **and** anus for gonorrhea;
 - Cultures (*not DNA probes or other screening tests*) of: vagina (in prepubertal or young teen girls), cervix (in postpubertal girls) or male urethra; **and** anus for chlamydia.
 - **Note:** A suggested examination technique to minimize discomfort while culturing the vagina in prepubertal girls would be for the examiner to use labial traction to identify the hymenal introitus. Then the examiner or an assistant should gently insert a minitip synthetic-fiber swab moistened with nonbacteriostatic saline or water through the introitus *without contacting the hymen*, and gently swab the distal vagina. *Avoid cotton or calcium alginate swabs.*
 - Blood should be drawn for syphilis, HIV, HBV, and HCV.
 - Wet prep of discharge for trichomonas, clue cells, or leukorrhea (>10WBC/HPF).
 - Culture of vesicles or ulcers for HSV.

- In postpubertal females, if speculum exam is done, consider obtaining Pap smear.
7. *In the child aged 13 years or older with an STD, pregnancy, or examination findings suggesting sexual abuse or assault:* Does the adolescent give a history of sexual contact that is either non-consensual, or that took place with someone 3 or more years older? *NOTE: this is not the same as asking if he/she is "sexually active."* **If yes, the law enforcement agency where the abuse/assault occurred should be notified promptly.**
 8. If acute sexual assault (penetrating genital injury and/or contact with perpetrator's genitalia within the past 48 to 72 hours):
 - A forensic evidence collection kit should be utilized after contacting relevant law enforcement agency for authorization. *Record the Case ID number on the Child Abuse/Neglect protocol or exam record.*
 - Cultures and blood for STD's should generally *not* be obtained unless there is an additional clinical indication.
 - DNA probes and other screening tests for STD should generally not be obtained (see above).
 - Prophylactic antibiotic therapy against gonorrhea and chlamydia infection should be administered. Refer to Centers for Disease Control or American Academy of Pediatrics current recommendations.
 - Prophylactic antiretroviral therapy may be offered to the victim if the assault involved the transfer of secretions, particularly if the alleged perpetrator is known to have HIV infection or to use intravenous drugs. Refer to Centers for Disease Control or American Academy of Pediatrics current recommendations.
 - Emergency contraception should be offered to all pubertal or postpubertal female victims. Contact Gynecology consultant or Office of Population Research website (<http://ec.princeton.edu/>) for current guidelines.
 - Consult Gynecology or Surgery in cases of severe anogenital injury.
 9. Whenever possible, arrange medical followup according to the following schedule:
 - In 2-3 weeks for re-examination and possible re-evaluation for STD and/or pregnancy;
 - In 6, 12, and 24 weeks with PCP or appropriate specialist for followup examination and testing for STD's, especially HIV.
 10. Refer for psychological counseling. Crisis counseling for child and family is often necessary.

D. Suspected child neglect.

1. Age 0-2 years: skeletal survey in all cases with visible acute injuries.
2. Age 2-5 years: skeletal survey should be considered if visible acute injuries.
3. Nuclear medicine bone scan (or repeat skeletal survey in 5-7 days) if index of suspicion for skeletal injury remains high despite negative initial skeletal survey.
4. MRI scan of head if there is a suspicion for subacute or chronic intracranial injury.

5. Complete physical examination, including inspection of genitalia and search for dysmorphic features.
6. Developmental assessment.
7. Laboratory evaluation: CBC, electrolytes, glucose, urinalysis, urine culture. Other labs as indicated clinically (e.g., lead level).
8. Nutrition consult/assessment with caloric quantification if possible.
9. Other consults (Developmental Pediatrics, Genetics, etc.) as indicated clinically.
10. Document child's caloric intake, weight gain, and response to hospital staff.
11. Document level of parental involvement and any concerns regarding inappropriate parental behaviors, attachment, statements, or level of knowledge regarding the child, his/her care, or his/her condition.

IV. REFERENCES

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5. American Academy of Pediatrics Committee on Child Abuse and Neglect and the American Academy of Pediatric Dentistry Ad Hoc Work Group on Child Abuse and Neglect, "Oral and Dental Aspects of Child Abuse and Neglect." *Pediatrics* 1999; 348-350.
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8. Block RW. "Child Abuse—Controversies and Imposters." *Curr Probl Pediatr* 1999; 29: 253-272.
9. Centers for Disease Control and Prevention. "Guidelines for Treatment of Sexually Transmitted Diseases." *Morbidity and Mortality Weekly Report* 1998; 47: 1-116

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11. Reece RM, ed. *Child Abuse: Medical Diagnosis and Management*. Philadelphia, Lea & Febiger, 1994. (various chapters)
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13. Texas Family Code
 - Chapter 32: Consent to Treatment of Child by Non-Parent or Child
 - Chapter 261: Investigation Of Report Of Child Abuse Or Neglect
14. Texas Pediatric Society Committee on Child Abuse. "The Pediatrician's Role in Child Abuse." *Texas Medicine* 1999; 95: 69-71.

ATTACHMENTS:

- 1. TPS Suspected Physical Abuse Protocol Form**
- 2. TPS Suspected Sexual Abuse/Assault Protocol Form**