Southern Minnesota Regional Trauma Advisory Committee (SMRTAC)

Regional Practice Management Guideline

Initial Management of Suspected Child Physical Abuse

Pediatric **Practice Management Guideline**	**Effective: 6/2015**
Contact: SMRTAC Coordinator	**Last Reviewed: 11/2020, Approved 2/2021**

Purpose

To provide a consistent approach to the care of injured children caused by suspected child physical abuse.

Definitions

Pediatric Trauma Patient: Defined as a child less than or equal to 14 years of age evaluated or admitted for an injury.

Child Physical Abuse: Any injury that is purposefully inflicted upon a child.

Policy Statements

1. Children are vulnerable to many forms of maltreatment.
2. Clinicians that care for children need to have a high index of suspicion for physical abuse as presentation can vary.
3. Appropriate evaluation and care of physical abuse patients requires a multi-disciplinary approach.
4. Children who present with suspected physical abuse injuries are considered pediatric trauma patients.
5. When abuse is considered, clinician is encouraged to contact the Mayo Child and Family Advocacy Program (MCFAP) /Child Abuse Pediatrics staff on call to discuss immediate care and potential need for follow-up MCFAP team (Rochester, Eau Claire, La Crosse) consult visit. Contact number is 507-284-2511. This resource is available for all hospital, clinic, and EMS providers throughout the entire SMRTAC region regardless of affiliation.

Procedure Statements

1. Physical/history findings suggestive of child physical abuse include:
    A. Discrepancy in the reported history and physical findings.
    B. Bruising in infants /children not cruising (development skill)
    C. Intra-cranial bleeding without history of trauma
    D. Perioral/intraoral injuries
    E. Trauma to anogenital area
    F. Bruising with patterns
    G. Burn injuries without adequate explaining history
    H. TEN-4-FACES-P Bruising rule: Any bruise found in any of the following locations should trigger the possibility of pediatric physical abuse:
        - Torso
        - Ears
        - Neck
        - Any bruise on a child younger than 4 months
        - Frenulum
        - Angle of Jaw
        - Cheek
        - Eyelid
        - Subconjunctival hemorrhage
        - Any bruising to head for child <5 years old

    I. Normal exam does not rule out injuries

2. Physical exam and documentation
    A. PHYSICAL ABUSE, injuries include:
        1) BRUISES:
            a) One cannot date a bruise on exam; do not commit an age to your bruise description
            b) Describe and PHOTOGRAPH(according to the policy of the institution involved) the bruise: location, size, color, over bone, tender, swelling, shape
            c) History to include risks of bleeding or genetic disorder or other contributing medical (dermatitis)
            d) Note lack of bruises or sparred areas

        2) BURNS:
            a) Describe burn: location, shape, size; agent causing burn; take multiple photographs
            b) Examine for other injuries

        3) FRACTURES:
            a) History of injury.
            b) History of child's developmental ability
            c) One cannot rule out fractures, in child <2 year old, without skeletal survey

        4) HEAD TRAUMA:

a) Immediate labs: limited bleeding diathesis profile urine organic acids and serum amino acids and. serum acyl-carnitine profile
b) CT of head (non-contrast) indicated for all patients suspected acute physical abuse injury under the age of 12 months age. For child over age 12 months CT done at examiners determination. If CT is positive: do MRI of head and c-spine; if CT is negative BUT admission neurologic exam was abnormal, do MRI of head. If concern for abuse and under age 2, do skeletal survey. CT can be done at the pediatric trauma center (PTC) as the 3D reconstruction of the skull can be done. The MRI can also be obtained at the PTC.

5) SKELETAL SURVEY CONSIDERATIONS:
   a) All physical abuse victims, bruises, fractures, burns or head trauma, under age 2
   b) A skeletal survey cannot be used to RULE OUT physical abuse
   c) Repeat skeletal survey in 3 weeks must be obtained
   d) Age 2-5 do physical exam; consider skeletal survey or isolated x-rays of abnormal areas
   e) Over age 5; isolated films of abnormal areas of bony exam
   f) Skeletal survey should be done prior to splint or cast placement
   g) Consider survey in older child <5, if unable to perform complete exam or multiple trauma or developmental delay in child

6) ABDOMINAL INJURY:
   a) Consider potential injury (in spite of no obvious injury and normal bowel sounds) for physical abuse victims or those with burns, bruises, fractures or head trauma.
   b) Any patient under age 2 with concerns for physical abuse, DO labs: SGOT, SGPT and Amylase. For older child consider doing these labs.
   c) IF, liver enzymes are over 80 or Amylase is elevated, consideration for abdominal CT, with contrast, should be discussed with pediatric surgical team

B. Reporting suspected child physical abuse
   1) All medical care providers are mandated reporters.
   2) Child abuse/neglect reporting to the county in which the patient resides is to be done verbally within 24 hours and written within 72 hours.
   3) NO child/teen leaves your location until a safety plan is in place (law enforcement or CPS must determine plan)

   Consider consultation (phone if outpatient plans or inpatient consult) with MCFAP team.

C. Transfer to a Designated Pediatric Trauma Center if the child's injuries or social situation exceed your capabilities. (See Pediatric Trauma Management Guideline for transfer criteria for all injuries including suspected physical abuse.)

Prepared by: SMRTAC Pediatric SubCommittee; SMRTAC leadership
Approvals: SMRTAC membership initial 6/11/2015, updated 11/2020, approved 2/2021

Disclaimer: This is a general guideline and is not intended as a substitute for clinical judgment or as a protocol for the management of all trauma patients.