CHILD ABUSE / NEGLECT RED FLAGS

I. INTRODUCTION: Defining the Role of the ED Physician

ED physicians are NOT experts in Chid Abuse/Neglect. ED physicians are NOT expected to decide whether or not an injury in a child is due to abuse, and should NEVER feel burdened to assume sole responsibility for this decision. The role of the ED physician IS to screen patients for possible abuse or neglect by identifying 'Red-Flags'. These Red Flags are listed below. Remember that while some Red-Flags may seem benign and unimpressive enough to disregard in the ED, child abuse or neglect is a potentially life-threatening diagnosis which can result in death if missed on the initial ED visit . Abuse and neglect have often been diagnosed in the ED on patients who presented with unrelated chief complaints (ie-fever, etc) when suspicious injuries (eg- bruises, belt marks, burns, etc) were found on routine exam, which again emphasizes the importance and **need to FULLY UNDRESS** and perform a FULL H&P on EVERY infant and pre-verbal child presenting to the ED. **Regardless of the chief complaint, a complete "head-to-toe" physical exam on EVERY infant and pre-verbal child is the most essential part of the ED physician's routine screening for & detection of child abuse.** Regardless of how appropriate or nice a caretaker may seem to you, once a Red Flag has been identified NEVER feel comfortable simply attributing such injuries to another cause (no matter how plausible the story may seem), Rather, ANY Red Flag demands further screening in the ED to rule out abuse (or neglect) . Studies have shown that by far the MOST COMMON CAUSE of a missed diagnosis of child abuse or neglect in the ED is either : 1) Failure to ask the appropriate questions that might elicit a Red-Flag, or 2) 'Blowing-off' and ignoring a Red-Flag that's actually been identified in the history or exam (because caretaker seems nice, etc).

TAKE-HOME MESSAGES:

1) ALWAYS DO A COMPLETE H&P ON EVERY INFANT & TODDLER!
2) FULLY UNDRESS ALL INFANTS & TODDLERS → WITHOUT EXCEPTION!
3) NEVER IGNORE A RED-FLAG ! (See list below).

II. RED-FLAGS:

1. **Any injury not explained by the history or not consistent with the child's age or developmental level.**
2. **History of roll off bed in infant < 4 months old.**
3. **ANY fracture in a child < 1 year old.**

   Fractures more characteristic of abuse:

   i. **Spiral fractures (Exception: Toddler's Fracture)**
   ii. **Bucket-handle fracture**
   iii. **High energy fractures**
   iv. **Complex skull fractures**

4. **ANY burn**

   Burns more characteristic of abuse:

   i. **Dip burns**
   ii. **Stocking glove distribution**
   iii. **Brand marks**

5. **Central or extensive bruising.**
6. **Delay in seeking treatment.**
7. **Brought to the ER by someone other than the parent/guardian who was present with the child at the time of injury.**
8. **Injury incurred while with babysitter.**
9. **Genital or rectal trauma.**
10. **Vaginal bleeding in an infant or young child.**
11. **Vaginal discharge in an infant or young child.**

III. ALWAYS REMEMBER 4 THINGS:

1) Just like MI, Sepsis, etc., Child Abuse/Neglect is also a potentially life-threatening diagnosis which can result in death if missed on the initial ED visit. Therefore, follow the same axiom as you do when you're considering any other potentially life-threatening condition in your differential diagnosis, namely: "When in doubt, rule it out!" -ie-whether simply by detailed history and exam, or if necessary by doing further testing, imaging, involving consultation with others, etc.

2) REGARDLESS of how nice a caretaker seems to you ANY of these Red Flags demands further screening in the ED to rule out abuse (or neglect) . In many cases, this 'further screening' simply means doing a more thorough history and delving into details of the setting and events surrounding the injury, as well as a careful and more complete exam, that help you to determine 1) There was appropriate supervision*, 2) The injury is consistent with the patient's age and developmental level/abilities**, and 3) The location and appearance of the injury is consistent with the story□, and 4) The appearance of the injury not suspicious for abuse□□.

Examples:

* **"appropriate supervision" –**
YES: mother in same room changing diaper & turns around momentarily and baby rolls off bed
NO: mother left her 9 year old with baby while she went to get something

** **"injury consistent with developmental level/abilities" –**
YES: 4 month old with scalp hematoma who rolled off bed and hit head on floor
NO: 3 month old with scalp hematoma who rolled off bed and hit head on floor (ie- infants usually don't start to roll over until age of 4 months)

□ **"location and appearance of the injury is consistent with the story" -**
YES: small, non-depressed skull fracture in 4 month old fell from mother's arms & hit back of head on floor
NO: small, non-depressed skull fracture in 6 month old fell backward from sitting position on floor & hit back of head on the floor.

□□ **"appearance of the injury not suspicious for abuse" -**
YES: 2 year old multiple small bruises on anterior lower legs/shins (ie- consistent with falls while running/playing)
NO: 2 year old with multiple small bruises on buttocks or central back (ie-unusual areas for innocent bruising, more concerning for abuse)

3) Studies have shown that by far the MOST COMMON CAUSE of a missed diagnosis of child abuse or neglect in the ED is either : 1) Failure to ask the appropriate questions that might elicit a Red-Flag, or 2) 'Blowing-off' and ignoring a Red-Flag that's actually been identified in the history or exam (because caretaker seems nice, etc).

4) Never feel burdened, as the emergency physician, to assume sole responsibility for your decision. When uncertain, DON'T GO IT ALONE! When your history and exam is NOT reassuring, and/or leave you uncertain of how to proceed, take it to the next level and consult with others to help you decide on what to do-eg- Social Work services or Child Advocacy Center consultation (when either or both are available at your ED), or else calling your nearest tertiary hospital Pediatric ED to speak with an attending there to consult with them and ask for advice about the case.

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