Suspected Child Abuse:
Emergency Department Management
Clinical Practice Guideline (CPG)

Clinical Practice Guideline
Protocol Approved by: Divisions of Pediatric Emergency Medicine and Pediatric Surgery, and Child Protection Team
Date of Approval: 1/14
SUSPECTED CHILD ABUSE:
CLINICAL PRACTICE GUIDELINE (CPG)

BACKGROUND:

Injuries from child abuse account for significant morbidity and mortality in the pediatric population. It also accounts for long term disability when these children become adults. Despite best efforts to intervene, abuse still goes unrecognized and misdiagnosed. In one study on abusive head trauma, 30% of the infants were misdiagnosed the first time they sought medical care. In order to reduce this risk we must have a high index of suspicion in the right clinical situation and have a strong assessment tool to evaluate these children.

The first step in the assessment is a detailed and thorough history for the event. A member of the ED team should take this history. Consult services will obtain their own history but their histories usually are not as detailed as an ED history and may not include family and medical histories, etc. These details are very important to distinguish abuse from accidental injury. Secondly, social work should be consulted on all patients where there is a concern for abuse. The social worker will perform an assessment of the social situation (i.e. family dynamics), who lives in the home, the number of children, history of domestic violence, drug or alcohol issues, history of Missouri Children’s Division or DCFS involvement, etc. Social workers do not obtain a medical history; that is the responsibility of the treating physician.

The appropriate studies and consults are ordered at the discretion of the ED attending. Once preliminary results are obtained, it is the responsibility of the ED attending to make the determination as to whether the injury is suspicious for abuse or not. If the injury is deemed concerning for abuse, then the social worker will make the report to Children’s Division, the
Division of Children and Family Services, and/or the appropriate Law Enforcement Agency. *All victims of child abuse who are being admitted* to the hospital, even if for non-medical reasons, (i.e. for social reasons), *must have a Trauma Consult.*

Listed next are the important Clinical Pathways to aid in the evaluation of an infant or child who is suspected to be the victim of Physical Abuse (references 1-16) and/or Sexual Abuse (reference 17).
Age 0 - 2

**Skeletal Surveys**
- **Complete Skeletal Survey Indicated when:**
  - Abuse suspected by history, or
  - Injury pattern is suspicious for abuse including:
    - Bruising, particularly in a non-ambulatory child
    - Burns
    - Fracture in non-ambulatory child
    - Long bone fracture inconsistent with the reported mechanism
    - Abusive Head Injury or skull fracture
    - Intra-abdominal injury
    - Socially isolated
- **Repeat Survey is Indicated In 3 Weeks whenever:**
  - Abuse is still suspected after initial evaluation
- **Complete Skeletal Survey Indicated for Sibling when:**
  - Sibling is twin of primary patient
  - Sibling is < 2 year old

**CT**
- **Head CT Indicated when:**
  - Child abuse is suspected by history or physical findings
- **Abdominal CT Indicated (in consultation with the trauma service) for:**
  - Clinical signs of intra-abdominal trauma or elevated LFT’s

**Ophthalmologic Studies**
- **Ophthalmologic Consult with Indirect Ophthalmoscopic Exam Indicated when:**
  - Abuse suspected by history, or
  - Injury pattern is suspicious for abuse including:
    - Bruising
    - Burns
    - Fracture in non-ambulatory child
    - Long bone fracture inconsistent with the reported mechanism
    - Abusive Head Injury or skull fracture
    - Abdominal injury
- **Ophthalmologic Consult with Indirect Ophthalmoscopic Exam Indicated for Sibling when:**
  - Sibling is twin of primary patient
  - Sibling is < 1 year old

**Lab Studies**
- **Suspected child abuse with blunt trauma (e.g. intra-abdominal injury, head injury, or fracture)**
  - CBC, PT/PTT, INR, CMP, Amylase, Lipase, UA, Urine Drug Screen
- **Suspected child abuse with isolated cutaneous injuries (e.g. bruising)**
  - CBC, PT/PTT, INR
  - If extensive hematoma’s, consider UA, myoglobin, CPK, renal panel

**Consultations**
- **Ophthalmology**
- **Neurosurgery if abnormal head CT or skull fracture**
- **Orthopaedics for fractures**
- **Trauma Surgery for all admissions**
- **Social Work for all evaluations**
Age 2 - 5

Radiological Studies
- **Selective Radiologic Studies** Indicated when:
  - Abuse suspected by history, or
  - Abuse suspected by clinical examination
- **Complete Skeletal Survey** Indicated when:
  - Child is disabled or immobilized, including children with:
    - Cerebral Palsy
    - Neuromuscular disorders
- **Repeat Studies are Indicated In 3 Weeks whenever:**
  - Abuse is still suspected after initial evaluation

CT
- **Head CT** Indicated for:
  - Facial or neck bruising
  - Neurological symptoms upon presentation or by history
- **Abdominal CT** Indicated (in consultation with the trauma service) for:
  - Clinical signs of intra-abdominal trauma or elevated LFT's

Ophthalmologic Studies
- **Ophthalmologic Consult with Indirect Ophthalmoscopic Exam** Indicated when:
  - A facial or head injury is c/w abuse

Lab Studies
- **Suspected child abuse with bunt trauma (e.g. intra-abdominal injury, head injury, or fracture)**
  - CBC, PT/PTT, INR, CMP, Amylase, Lipase, UA, Urine Drug Screen
- **Suspected child abuse with isolated cutaneous injuries (e.g. bruising)**
  - CBC, PT/PTT, INR
  - If extensive hematomas, consider UA, myoglobin, CPK, renal panel

Consultations
- **Ophthalmology when facial or head injury is c/w abuse**
- **Neurosurgery if abnormal head CT or skull fracture**
- **Orthopaedics for fractures**
- **Trauma Surgery for all admissions**
- **Social Work for all evaluations**
**Age > 5**

**Radiological Studies**
- **Selective Radiologic Studies Indicated when:**
  - Abuse suspected by history, or
  - Abuse suspected by clinical examination
- **Repeat Studies are Indicated In 3 Weeks whenever:**
  - Abuse is still suspected after initial evaluation

**CT**
- **Head CT Indicated for**
  - Facial or neck bruising
  - Neurological symptoms upon presentation or by history
- **Abdominal CT Indicated (in consultation with the trauma service) for**
  - Clinical signs of intra-abdominal trauma or elevated LFT's

**Ophthalmologic Studies**
- **Ophthalmologic Consult with Indirect Ophthalmoscopic Exam Indicated when:**
  - A facial or head injury is c/w abuse

**Lab Studies**
- **Suspected child abuse with blunt trauma (e.g. intra-abdominal injury, head injury, or fracture)**
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- **Suspected child abuse with isolated cutaneous injuries (e.g. bruising)**
  - CBC, PT/PTT, INR
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**Consultations**
- **Ophthalmology when facial or head injury is c/w abuse**
- **Neurosurgery if abnormal head CT or skull fracture**
- **Orthopaedics for fractures**
- **Trauma Surgery for all admissions**
- **Social Work for all evaluations**
 SEXUAL ASSAULT EVIDENCE COLLECTION

Sexual Assault Evidence Collection Kits are available in the GYN Room. A kit should be completed on any patient who presents within 72 hours of a sexual assault.

Evidence is often present on the clothing the victim wore at the time of the assault. Evidence can even be transferred onto clothing if the victim changes after the assault. This is especially true with children who are victims of sexual assault. When any victim arrives to the Emergency Department, ask about the clothing they are wearing. If you decide to collect their clothing, have them undress on a clean sheet placed on the floor to avoid contamination. Each item of clothing should be placed in its own bag, sealed and identified with pt’s name and item of clothing. All the bags then should be placed in one large bag and labeled with pt’s name and sealed. The bag is then given to the appropriate Law Enforcement agency.

Ask if the victim was licked, kissed or bitten. Victims often do not volunteer this information and need to be questioned. This is another valuable source of DNA evidence. The area in question should be swabbed with a sterile water moistened cotton tip swab on a wood base. The swab should be rolled across the area. It should then be placed in the drier. A second dry swab should then be rolled across the area and placed in the drier. Please obtain two swabs from each area. Swabs from the same area may be placed in the same cardholder. Label the area they are from on the cardholder and sheet. The information sheet and the cardholders are then placed in the evidence kit and sealed.

The Blue Max Light can aid in detection of dried secretions that may yield DNA evidence. The light is shone on the patient’s skin while viewing through the orange filter. Any area that fluoresces should be swabbed in the manner described above.
Pre-Pubertal Victims of Sexual Abuse

Acute Assault (assault occurring less than 72 hours prior to presentation)

1. Perform a Sexual Assault Evidence Collection Kit.
2. Do not obtain cultures or Urine NAAT Studies
3. Do not obtain serologic studies.
4. Do not treat with antibiotics.
5. Prophylaxis for Hepatitis B if no history of immunization or unknown history.
6. Prophylaxis for HIV if assault meets high risk criteria.*
7. Follow up at SAM Clinic in 2 weeks post assault for cultures.
8. Obtain serologic studies in 6 weeks, 3 months and 6 months post assault for RPR (for Syphilis), Hepatitis B & C, and HIV.

Sub-Acute Assault (assault occurring between 72 hours and 2 weeks prior to presentation)

1. Do not perform a Sexual Assault Evidence Kit.
2. Do not obtain cultures or Urine NAAT Studies.
3. Do not obtain serologic studies.
4. Do not treat with antibiotics.
5. Prophylaxis with Hepatitis B if no history of immunization or history unknown.
6. Follow up at SAM Clinic 2 weeks post assault to obtain cultures.
7. Obtain serologic studies for RPR (for Syphilis), Hepatitis B & C, and HIV 6 weeks, 3 months and 6 months post assault.

Non-Acute Assault (assault occurring greater than 2 weeks prior to presentation)

1. Do not perform a Sexual Assault Evidence Collection Kit.
2. For female victims: Based in physical findings, obtain urine NAAT for Gonorrhea & Chlamydia from DIRTY urine if vaginal-genital contact or vaginal-oral contact by disclosure or by suspicion on exam. From rectal and oral sites must use culture (Do not use urine NAAT). If vaginal discharge is present, obtain a culture for Trichomonas as well.
3. For male victims: must obtain GC and Chlamydia culture (Do not use urine NAAT)
4. Obtain serology for, Hepatitis B & C, HIV and RPR for Syphilis at 6 weeks, 3 months and 6 months post assault.
5. Administer antibiotics only if clinically indicated.
6. Do not provide prophylaxis for HIV or Hepatitis.

* HIV Post Exposure Prophylaxis s Guidelines: As these recommendations are often changing based on available evidence, please refer to the CDC website for the most up-to-date recommendations.

Post-Pubertal Victims of Sexual Abuse

Acute Assault (assault occurring less than 72 hours prior to presentation)

1. Perform a Sexual Assault Evidence Collection Kit.
2. As indicted by disclosure and physical findings, if sexually active and symptomatic of a previously acquired sexually transmitted infection, consider obtaining the following: A) Gen Probe Aptima Unisex Swab for Gonorrhea and Chlamydia (cervical & penile only) or may use Urine NAAT for GC and Chlamydia for both male and female victims; B) If suspicious for pharyngeal or rectal GC, must obtain a culture [If rectal or pharyngeal specimens are being obtained, these must be cultures (GC from pharynx, GC and chlamydia from rectum)]; C) For vaginal discharge, culture for Trichomonas using TRICH Pouch; and D) Obtain serology for Hepatitis B & C, HIV and RPR (for Syphilis).
3. Regardless of symptomatology, treat for Gonorrhea, Chlamydia and Trichomonas.*
4. Serology reflective of the assault is not obtained at this time but at 6, weeks, 3 and 6 months post assault for Hepatitis B & C and HIV, and RPR for Syphilis.
5. Administer prophylaxis for pregnancy if urine HCG is negative.
6. Administer Hepatitis B if no history of immunization for Hepatitis B or history unknown.
7. Administer prophylaxis for HIV if assault meets high risk criteria. **
8. Follow up with PMD or GYN based on treatment plan and examination.

Sub-Acute Assault (assault occurring more than 72 hours but less than 2 weeks prior to presentation)

1. Do not perform a Sexual Assault Evidence Collection Kit.
2. As indicted by disclosure and physical findings, if victim is sexually active and symptomatic of a previously acquired sexually transmitted infection, consider obtaining: A) Cultures for Gonorrhea, Chlamydia (or Gen Probe Aptima Unisex Swabs for GC and Chlamydia or Urine NAAT tests, as noted above); B) Culture Trichomonas (using Trich pouch); and C) Serology for Hepatitis B & C, HIV, and RPR (for Syphilis).
3. Regardless of symptomatology, treat for Gonorrhea, Chlamydia and Trichomonas.*
4. Serology reflective of the assault is not obtained at this time but 6 weeks, 3 months and 6 months post assault for Hepatitis B & C, HIV and RPR (for Syphilis).
5. Do not provide prophylaxis against pregnancy or HIV.
6. Follow up with GYN or PMD based on treatment plan and examination.

Non-Acute Assault (assault occurring greater than 2 weeks prior to presentation)

1. Do not perform a Sexual Assault Evidence Collection Kit.
2. As indicted by disclosure and physical findings, obtain cultures for Gonorrhea (or Aptima Swabs or NAAT Tests, as noted above), and culture for Trichomonas (as above)
3. Obtain serological studies for Hepatitis B & C, and HIV, and RPR (for Syphilis) at 6 weeks, 3 months and 6 months post assault.
4. Treat if clinically indicated.
5. Do not provide any prophylaxis against pregnancy or HIV.
6. Follow up with GYN or PMD based on treatment plan and examination.

* See “Acute Rape Prophylaxis Guidelines” in this CPG

** HIV Post Exposure Prophylaxis Guidelines: As these recommendations are often changing based on available evidence, please refer to the CDC website for the most up-to-date recommendations.

GENITAL SPECIMEN COLLECTION
FOR VICTIMS OF SEXUAL ABUSE

IMPORTANT:

Regardless of the reported time since assault, if discharge is noted on any victim of a sexual assault, obtain a specimen of the discharge for culture (or Urine NAAT for GC/Chlamydia as outlined previously). Victims often do not disclose the extent of their assault on the first visit; this is especially true of pre-pubertal victims. Nothing is lost in obtaining a specimen at this time.

POST-PUBERTAL VICTIMS of SEXUAL ABUSE

Females

- If the adolescent female is sexual active and able to cooperate with a pelvic exam, perform cervical swabs for both DNA and detection of sexual transmitted infections with either culture media or Aptima Gen Probe Swabs or Urine NAAT Tests for GC and Chlamydia (cultures are no longer mandatory). Use a calgi swab for a Trichomonas specimen and use TRICH pouch.

Males

- For the male victim, use the Gen Probe (as above) in the urethra or Urine NAAT tests, and Trichomonas pouch.

PRE-PUBERTAL VICTIMES of SEXUAL ABUSE

Females

- Do not perform a pelvic examination on a pre-pubertal child. In place of vaginal cultures we can now use Urine NAAT tests for Gonorrhea and Chlamydia; however, this MUST be a Dirty specimen. If there is discharge, obtain a culture for Trichomonas. Specimens do not have to be intravaginal but may be obtained form the introits.

Males

- If a boy has a penile discharge, use a calgi swab to sample the discharge for Gonorrhea Chlamydia, and Trichomonas cultures only. You do no need to go into the urethra. If there is a history of discharge and likely exposure to an STD, but no discharge is noted on exam, moisten the swab and obtain your sample from the urethra. Again use the chocolate agar media and viral transport media. Do not use the Probe Kit or Urine NAAT Tests for Pre-pubertal males.
OTHER SITES OF SPECIMEN COLLECTION
AND LABORATORY STUDIES
FOR VICTIMS OF SEXUAL ABUSE

PHARYNGEAL SPECIMENS (Culture only for Gonorrhea):
To obtain cultures for Gonorrhea use a throat culture and the chocolate agar media. Do Not culture the pharynx for Chlamydia, and Do Not use Probes on pharyngeal specimens.

ANAL SPECIMENS (Culture for both Gonorrhea and Chlamydia):
To obtain anal cultures, use a calgi swab, plate the specimen on the chocolate agar media, and then place into viral transport media for a Chlamydia culture. Do Not use Probes on anal specimens.

SEROLOGY STUDIES:
• Hepatitis B Panel includes: IgM Antibody, Surface antibody and Surface antigen
• Hepatitis C antibody
• HIV Abbott HIV Ag/AB Combo tests for HIV p 24 antigen and antibodies to HIV type 1 and HIV type 2 (must obtain informed consent for HIV testing)
• RPR for Syphilis
Victims of Ongoing Sexual Assault

The management of children and adolescents who are victims of ongoing sexual abuse is often more difficult. Medical decision making must take into account when the last assault has taken place, as well as the length of time over which the abuse has occurred, the pubertal age of the child and the presence or absence of symptoms.

The following are guideline to assist you in your management of each individual case. As always, each specific case management should incorporate your clinical judgment and the individual needs of the patient.

1. Perform a Sexual Assault Evidence Kit if the last assault occurred within 72 hours of presenting to the Emergency Department.
2. Obtain appropriate specimens for Gonorrhea, Chlamydia, on both pre- and post-pubertal victims as indicated by the disclosure, area and physical findings.
3. Obtain Trichomonas on all pre- and post-pubertal victims with a discharge.
4. If it has been at least 6 weeks since an assault, obtain serology for Hepatitis B & C, HIV and RPR (for Syphilis).
5. Serology should be repeated at 3 months and 6 months post the most recent assault.
6. Prophylaxis for HIV should be offered if the most recent assault has occurred in the last 72 hours and meets the high risk criteria.*
7. If female patient is post pubertal and most recent assault occurred within the last 72 hours, offer prophylaxis for pregnancy prevention after obtaining a negative urine HCG.
8. Initiate Hepatitis B immunization if most recent assault occurred within 2 weeks and victim does not have a history of immunization against Hepatitis B or history is unknown.

* HIV Post Exposure Prophylaxis Guidelines: As these recommendations are often changing based on available evidence, please refer to the CDC website for the most up-to-date recommendations. [http://www.cdc.gov/std/treatment/2010/sexual-assault.htm](http://www.cdc.gov/std/treatment/2010/sexual-assault.htm)
ACUTE RAPE PROPHYLAXIS

Post-Pubertal Patients

CHLAMYDIA
Azithromycin 1 gram PO in single dose
Or
Doxycycline 100 mg PO BID for 7 days (cannot be used in pregnancy)

GONORRHEA
Ceftriaxone 250 mg IM
Or
Spectinomycin 2 grams IM if cephalosporin allergy
Or
Zithromax 2 grams if allergic to PCN

TRICHOMEONAS
Metronidazole 2 grams PO in a single dose

PREGNANCY PREVENTION
Plan B 1 tablet PO in ED and another in 12 hours

ANTI-NAUSEA
Zofran 4 mg in ED and discharge home with additional dose

ACUTE RAPE PROPHYLAXIS

All Victims (Both Pre- and Post-Pubertal)

HEPATITIS B
- IF Unvaccinated and perpetrator status is unknown, initiate vaccination series with Hepatitis B Vaccine
- IF Unvaccinated and perpetrator is known to be Hepatitis B positive (i.e., very high risk), administer HBIG and initiate Hepatitis B Vaccine series.
Transmission of HIV is a rare but potential consequence of a sexual assault. In the majority of cases, the HIV status of the alleged perpetrator is unavailable at the time the victim is receiving medical care. Post exposure prophylaxis is often the only option available to the victim.

The efficacy of post exposure prophylaxis in cases of sexual assault is unknown. The risks are related to the medications provided and include nausea, vomiting, abdominal discomfort, elevated liver enzymes and megaloblastic anemia. It is theorized post exposure prophylaxis is most efficacious when administered within 24 hours so the first dose should be administered in the ED.

To minimize the risks, it is recommended that these medications only be offered to those victims who are at high risk of being exposed to and acquiring HIV.

The CDC and the American Academy of Pediatrics have established criteria for patients for whom prophylaxis should be offered. These victims include those who are assaulted within 72 hours of presentation AND have at least one of the following:

1. Assaulted by a perpetrator who is known to be HIV positive or involved in HIV high risk behavior.
2. Assaulted by a stranger or multiple assailants.
3. Where there is anal or vaginal penetration with ejaculation.
4. Where there is anal or vaginal penetration and mucosal injury.
5. Who are assaulted within 72 hours of presenting to the Emergency Department.

Additional criteria includes:

1. The patient must agree to take all medications for a total for 28 days.
2. He or she cannot have a history of allergies to any of the prescribed medications.
3. He or she cannot be HIV positive.

Prior to beginning the regime, the patient must have a baseline CBC and ALT checked. Also, an HIV should be obtained as well but the result does not need to be known prior to the initiation of the first dose. After completion of the regime, a second CBC and ALT must be performed. This can be performed by a provider, preferably the primary care physician, who should also remain in contact with the patient during this time to monitor their ability to tolerate the medications.
DRUG REGIME:

The recommended drug regimen is Zidovudine (Retrovir) in combination with Lamivudine (Epivir) and Kaletra (Lopinavir & Retonavir). Above 45 kg, Combinvir may be given in place of Zidovudine and Lamivudine individually.

DOSAGES:

1. ZIDOVUDINE (RETROVIR): Children less than 45 kg
   
   180-240 mg/m2 every 12 hours (with max dose of 200 mg)

   Plus

   LAMIVUDINE (EPIVIR): Children less than 45 kg
   
   4mg/kg/dose every 12 hours (with max dose 150 mg)

   OR

   COMBIVIR (ZIDOVUDINE&LAMIVUDINE) Children over 45 kg
   
   Zidovudine 300 mg & Lamivudine 150 mg every 12 hours

2. KALETRA (LOPINAVIR & RETONAVIR) Infants greater than 6 months
   
   7 to 15 kg: 12mg/kg of the LPV every 12 hours
   
   15 to 40 kg: 10 mg/kg of the LPV every 12 hours
   
   12 years of age or 40 kg: 400 mg of LPV every 12 hours
   
   18 years of age: 800 mg of LPV once daily

* HIV Post Exposure Prophylaxis Guidelines: As these recommendations are often changing based on available evidence, please refer to the CDC website for the most up-to-date recommendations.
References


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