MEDICAL GUIDE FOR RESPONDING TO SEXUAL ABUSE

MEDICAL HISTORY:

Child history	Teen history
Interview parent/guardian alone	Interview patient alone
Interview child alone	Discuss confidentiality
Use open-ended questions	High risk behaviors
Identify patient's "body part" language	

HISTORY FOR ALL SEXUAL ABUSE PATIENTS:

Type of question	Details	
What?	Date, time, location, use of threats, force, restraint Memory loss, loss of consciousness, drugs, alcohol Contact — oral, vaginal, rectal, ejaculation, condom use Bleeding, pain, any other trauma After the event: bathed, changed clothing, ate, mouthwash, barrier contraceptive device	
Who?	Perpetrator identification, age relationship Current location	
When?	Beginning, last contact, last possible contact	
Where?	Location of any injury What has been done for this episode?	
Review of Systems/Symptoms	Genital complaints	• Vaginal irritation, bleeding, discharge • Dysuria, urinary frequency, enuresis • Rectal pain, bleeding
	Behavioral problems	• Recent “acting out”, hyperactivity, withdrawn • Sexually explicit behavior inappropriate for age • Nightmares or recent change in sleeping habits
Past Medical History	Menstrual history	• Menarche, LMP
	Sexual history	• STI, pregnancy, birth control, names of all consensual sex partners within last month • Recent antibiotics

		• Name of any individual that the patient has had any sexual relationships with during the past 96 hours.
	Immunization	• Hepatitis B
Social History	Family history of sexual abuse Exposure to explicit material Prior reports to police or social services History of violence in home Need for community resources	

SEXUAL ABUSE EXAM:
General Physical Exam
Complete physical exam including inspection of all body parts and thorough skin exam
Oral exam with attention to lips, tongue, buccal mucosa, frenula, palate, and teeth
Complete genital and anal examination

Forensic Evidence Collection if indicated – by state or county approved kit, per instructions on kit and include clothing

Photographs
Patient identification label -- Date of birth, medical record number
Photograph each injury separately -- Start with a photograph of the region and then do a close-up
Photograph against a neutral background (the wall is the best place)
Do not use a flash, use AUTO FOCUS -- Use MACRO mode
Set zoom to widest angle setting; move camera closer to the patient for close-up photographs
Always use the ruler in the close-up shot of the injury & with color guard

TREATMENT -- designed to help medical providers identify, screen, and treat children at-risk of transmission of infectious agents from blood or bodily fluid from sexual exposures.
Sexually transmitted disease testing and post-exposure prophylaxis
High risk features:
- Intoxicated, or altered patients
- Type of sexual contact
- Mucosal surface(s) involved
- Pubertal status
- Vaccination status for hepatitis B
- Assailant risk factors --
  - Is the assailant known to be infected with HIV, hepatitis B, or hepatitis C?
  - Does the assailant agree to be tested for HIV, hepatitis B, or hepatitis C?
- Any injuries that could increase the risk exposure

For a complete guideline, see:
Children's Hospital Clinical Care Pathway -- COMMUNITY (NON-OCCUPATIONAL) BLOOD OR BODILY FLUID EXPOSURE

MEDICAL GUIDE FOR RESPONDING TO PHYSICAL ABUSE AND NEGLECT

MEDICAL HISTORY

History is extremely important here; *every* medical diagnosis starts with history. The different types of history taken by providers are standard of care, and they are all important in confirming or ruling out a child abuse diagnosis. The medical diagnosis of physical abuse is based on the presence of a discrepant history; that is, the history offered by the caregiver is not consistent with the clinical findings. The discrepancy may exist because the history is absent, partial, changing over time, or simply illogical or improbable. A neglect history requires weighing the needs of the child versus ability of caregivers to meet the child's need.

HISTORY FOR ALL PHYSICAL ABUSE AND NEGLECT PATIENTS:

Type of question	Details
What?	What is the developmental age of the child? Does child have underlying medical conditions? What are child's basic health and wellbeing needs? What events preceded the injury? What is the severity of the injury? What is the apparent age of the injury? It the injury unexplained by history? Is there an absent, changing, or evolving history?
Who?	Who is primary caretaker of child? Who else helps take care of child? Who was with child at the time of injury? Does caregiver have unrealistic expectations for child? Does caregiver have prior history of abuse of caregiver as child? What was the caretaker's response to the injury? What is the affect of the caregiver? If the child is verbal, what does he or she say happened? Are there any adult or child witnesses?
When?	Is there a delay in seeking medical care? When did the child last feed and behave normally? Is there a recent crisis or stress in child's environment? Is there chronic social or physical isolation of child or family? Is there a triggering event causing loss of control in caregiver (the 3 Ts: tears, toileting, tantrums/temperament)? Is there a pattern of increasing severity or escalation of events over time?

Where?	What is the location of the injury? What has been done for this episode? What does scene or home environment look like?	
Review of Systems/Symptoms	General complaints	• Weight • Appetite • Sleep regulation • Energy level
	Behavioral problems	• Peer interactions • School performance and attendance • Mood • Recent "acting out", hyperactivity, withdrawn • Nightmares or recent change in sleeping habits
Past Medical History	Birth history	• Problems during mother's pregnancy • Prematurity
	Other history	• Chronic conditions • Medications • Access to care
	Immunization	• Up to date?
Social History	Who lives in the home? What is family employment and financial status? Is there domestic violence or substance abuse in the home? Prior family history of physical or sexual abuse? Any prior involvement with social services or law enforcement? What are the family support? What are the family strengths?	

PHYSICAL EXAM:

General Physical Exam

Complete physical exam including inspection of all body parts and thorough skin, oral and ear exam
Complete genital and anal examination

Forensic Evidence Collection if indicated – by state or county approved kit, per instructions on kit and include clothing

Photographs
Patient identification label
Date of birth, medical record number
Photograph each injury separately
Start with a photograph of the region and then do a close-up
Photograph against a neutral background (the wall is the best place)
Do not use a flash, use AUTO FOCUS.
Use MACRO mode (press flower button on back of camera to focus on close objects)
Set zoom to widest angle setting; move camera closer to the patient for close-up photographs
Always use the ruler in the close-up shot of the injury
Always use ruler with color guide (in cart) to show size, detail of injury

TREATMENT -- designed to help medical providers identify, screen, and treat children at-risk of physical abuse and neglect.

Recommended evaluation in cases of suspected physical abuse:

<table>
<tr>
<td><u>Laboratory</u>
General for <u>most patients</u>:
1. ALT, AST
2. Consider urine toxicology screen</td>
<td>If main is <u>bruising</u> or <u>intracranial hemorrhage</u>
1. CBC; PT/PTT/INR (if concern of low/falling Hgb, repeat in am with retic)
2. If extensive bruising, consider measuring CPK
If bruising/bleeding more than expected, but non-specific in patter, consider additional evaluation for possible bleeding disorder, contact hematology.</td>
<td>Multiple or unusual/atypical fractures:
1. Calcium, phosphorus, Mg, Alk Phos, 1-Oh vitamin D, parathyroid hormone
2. If bones abnormal on X-ray, consider 25-hydroxy Vitamin D battery; very rarely consider DNA for collagen A1, A2/mutation for OI</td>
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<tr>
<td colspan="3"><u>Radiology</u>
1. Skeletal survey <2 yrs.
2. Head CT (non-contrast with 3D reconstruction) if:
a. Any concern for abuse and <6 months old
b. <12 months old with moderate or high concern for abuse.
c. Abnormal mental status, bulging fontanel, seizures, ALTE, vomiting >1 episode.
3. Abdominal CT if:
a. s/sx of abdominal trauma
b. >80 IU/L ALT or AST
c. Bruising to abdomen or torso</td>
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