ED Bruising v2.1: Screening/Work-up

PHASE I (E.D.)

**High Risk Screening (to be completed by RN)**
- <6 months full body skin exam
- 6 months – 4 years (48 months) skin exam in TEN (torso, ears, neck) region
- Torso includes back and front of abdomen and genital/buttock region. Genital/buttock exam to be done by MD in children over 6 months

**Inclusion Criteria**
- <48 months old
- Any patient with clinical concern for abusive bruising
- Genital bruising

**Exclusion Criteria**
- Other non-accidental trauma (NAT) without bruising
- Sexual assault with or without bruising

**Urgent Care Transfer Recommendations**
If concerned for neglect or abuse (including bruising) consult SCAN and transfer to the ED for further work-up
See "Suspected Child Abuse & Neglect” job aid for transfer recommendations*(for SCH only)

**HISTORY AND PHYSICAL**
- Historical indicators of abuse
- Development
- Family bleeding history
- Physical exam indicators of abuse
- Head circumference

**LABS**
- CBC, PT/INR, PTT, VWF antigen
- AST/ALT, lipase, urinalysis
- Coagulation storage specimen (blue top drawn for hold)

**SOCIAL WORK CONSULT**
- Full Child Abuse Protection Assessment
  (8a-3p: SCAN MSW; Afterhours, holidays and weekends: Inpatient Social Work Consult)
- Patient Family Risk Assessment (PFRA) form complete (for SCH only)

**IMAGING**
- <6 months of age: Head imaging, skeletal survey
- 6 months - 24 months: Head imaging (for seizure or neurologic signs and symptoms, OFC >95%, history of head trauma), skeletal survey
- >24 months: Head and/or focused skeletal imaging only if clinically indicated

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**WORK-UP and INTERVENTIONS**
Use the Non-Accidental Trauma/Abuse Evaluation Power Plan

**Approved & Citation**
**Summary of Version Changes**
**Explanations of Evidence Ratings**
ED Attending/Fellow with Resident and Social Work huddle, consult SCAN MD together in person or via phone to discuss:

**ED Provider**
- History and Physical
- Results of current work-up
- Consults

**SCAN MD**
- Additional work up needed
- Consults
- Reporting to Child Protective Services (CPS) and/or Law Enforcement (LE) and documentation of decision and communication
- Disposition and safety planning
- Use standard SCAN template*

**Social Work**
- Psychosocial risk factors
- Disposition and safety planning

- Consider examining siblings or other children in the home if conclusion in index child is abuse

**Consensus with SCAN MD regarding abuse diagnosis**
- Concerning for abuse
- Not concerning for abuse
- Indeterminate

**Disposition and Safety Plan**
- Placement (i.e., home, protective custody, foster care, admitted, medical hold)
- Reporting to Child Protective Services
- Reporting to Law Enforcement

**Discharge Criteria**
- Safe discharge plan
- Work-up complete
- Agreement with SCAN on reporting to CPS/LE
- Follow-up arranged (with providers, further testing)

**Follow-up**
- Primary Care
- Harborview Center for Sexual Assault and Traumatic Stress (HCSATS) or other victim service center
- Further SCAN recommendations (i.e., additional imaging)

*For questions concerning this pathway, contact: EDBruising@seattlechildrens.org
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Last Updated: May 2017
Next Expected Revision: November 2021
Learning Objectives

Upon completion of this module, participants will be better able to:

1. Describe why bruising is considered a sentinel injury
2. Identify patients at risk for abusive bruising
3. Identify bruises concerning for abuse
4. Identify patients appropriate for the bruising pathway
5. Initiate the appropriate workup for a patient with concerning bruises
6. Identify resources that can be accessed to help distinguish abusive from accidental bruising
Scope of Problem

- Bruising is the most common and most visible sign of physical abuse
- Missed as sign of physical abuse in up to 44% of fatal or near-fatal cases
- May be the only visible sign of injury or signal of internal injury
- There have been multiple cases of bruising not recognized as abusive bruising at Seattle Children’s Hospital where the child was discharged and returned to medical attention with either new injuries or dead


Bruising can look innocuous and benign or more involved and concerning
Historical indicators of abuse

When obtaining a history from the caregiver(s) pay special note for the following:

• No or vague explanation for a significant injury
• Changing story of how the injury occurred
• Explanation provided is inconsistent with the pattern, age, or severity of the injury or injuries
• Explanation given is inconsistent with the child’s physical and/or developmental capabilities
• Different witnesses provide different explanations
• Unexplained or unexpected delay in seeking medical care

Christian CW, Committee on Child Abuse and Neglect, The Evaluation of Suspected Child Physical Abuse, Pediatr 2015;135(5);e1337-e1354
Bruising concerning for abuse

“Those who don’t cruise rarely bruise”

- Bruises in infants < 6 months of age or non-ambulatory children
- Bruising in unusual locations in any age child:
  Examples include:
  - Ear pinna
  - Genital bruising
  - Neck, under chin
  - Torso, buttocks
  - Flexural bruises
  - Patterned bruises
  - Loop marks
  - Hand print
- Bruising in medically complex children
- TEN-4 Bruising Clinical Decision Rule (next slide)

**TEN-4 decision rule**

- ANY bruise in a child < 4 months of age
- OR
- Bruising present in TEN region (torso, ears, neck)
  - Torso includes: chest, abdomen, back**, buttocks, GU & hip
- AND
- No confirmed accident in a public setting that accounts for bruising in TEN region or infant < 4 months

- Sensitivity of 97% and specificity of 84% for predicting abuse

**In many cases bruising over the spine is ok – “The Spine is Fine”**

High Risk Populations

- Children with special health care needs
- Children who are non-communicative
- Any child who resides in a home with a child who has suspected abusive injuries should have a full, age-appropriate screening for occult injuries
- Mental health patients
What are the distinguishing features of abusive bruising in children?

- **Screen all Emergency Department patients less than 4 years of age for bruising, specifically bruising in the TEN (torso, ears, neck) region for children under 4 years, any bruising in infants < 6 months and patterned bruising.** [LOE (Guideline 2009, Maguire 2013, Anderst 2013 Expert Opinion)]

- **Place all Emergency Department patients less than 4 years of age in a gown to allow better visualization for bruising.** [LOE: expert opinion]

- **Initiate ED bruising pathway for patients with high risk bruising.** [LOE: expert opinion]

How are the distinguishing features of abusive bruising the same or different across the age spectrum in children?

- **Have a high level of concern for non-accidental trauma when a non-mobile child presents with a bruise or a child < 4 years of age with bruising in the TEN region (torso, ears, neck).** [LOE: Maguire 2013, Guideline 2009]

- **Initiate non-accidental trauma work-up for bruising if concerning and/or high risk bruises are identified.** [LOE: Maguire 2013, Guideline 2009]
What specific laboratory evaluation is recommendation for children with suspected abusive bruising?

- *If < 4 years of age and concerning bruise confirmed, obtain CBC, PT/INR, PTT, von Willebrand antigen, liver enzymes, lipase, urinalysis and have a coagulation storage specimen held. [LOE: Expert opinion (Kellogg 2007)]*

- *If > 4 years of age and concerning bruise confirmed, discuss with child protection team physician on call to help determine potential work-up. [LOE: Expert opinion (Kellogg 2007)]*
What specific imaging is recommended for children with suspected abusive bruising?

- **Obtain bone survey if < 24mths and concerning bruise identified for age or if clinical condition precludes reliable exam (medically complex, obtunded or altered mental status)** [LOE: Guideline 2012]

- **Consider bone survey if > 24 months and clinical condition precludes reliable exam (medically complex, obtunded or altered mental status)** [LOE: Guideline 2012]

- **Obtain head imaging (non-contrast CT) if < 6 months and bruise identified, focal neurologic changes or clinical condition precludes reliable exam (medically complex, obtunded or altered mental status), or history of head trauma.** [LOE: Guideline 2012]

- **Obtain focal radiographs per exam when concerned for skeletal injury in children > 24 months.** [LOE: Guideline 2012]
ED Bruising photography procedures

• “Real time” photography is helpful in allowing the SCAN physician to see the concerning lesion while the child is still in the ED. The system we use for this is Accellion. It does not replace the need for medical photography.

• Accellion photos should be used when a bruise is identified in a high risk group and the ED physician is considering going off pathway.

  eg. A 2-year old child with a bruise to the ear and a story of falling off of a slide.
A “huddle” with the ED physician, social work and SCAN physician will occur once the initial evaluation/workup is complete.

- The goals of the huddle are:
  - To share information regarding circumstances surrounding the injury
  - To determine whether further workup is necessary
  - To determine disposition of the child including:
    - CPS and/or law enforcement involvement
    - Appropriate follow-up (HCSATS, PCP, repeat imaging)
    - Recommendations to CPS & law enforcement on likelihood of abuse
Important Medical Information for Team Huddle

When calling the SCAN physician the important *medical* information communicated by medical team:

- Circumstances surrounding injury
  - How, when, where, under whose supervision
- Developmental level of the child (crawling, cruising, walking)
- Family medical history (bleeding disorders, easy bruising or fractures)
- Head circumference in children under 1 year of age
- ANY other injuries
- Results of initial workup

Important Social Information for Team Huddle

When calling the SCAN physician the important *social* information communicated by the social worker:

- The timeline of events leading up to the injury
- Psycho-social risk factors (i.e. domestic violence, mental illness, drug use)
- Who is the legal guardian of the child
- Previous history of CPS or law enforcement involvement
- Other children in the household
Approved by the CSW ED Bruising Pathway team for October 6, 2016.

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| Surgeon-in-Chief                           | Bob Sawin, MD |


Please cite as:
Summary of Version Changes

- **Version 1.0 (11/22/2016):** Go live
- **Version 2.0 (2/15/2017):** Algorithm revised to clarify off-pathway option
- **Version 2.1 (5/24/17):** Updated TEN-4 FACES slide to align with SCH Privacy Policies
Medical Disclaimer

Medicine is an ever-changing science. As new research and clinical experience broaden our knowledge, changes in treatment and drug therapy are required.

The authors have checked with sources believed to be reliable in their efforts to provide information that is complete and generally in accord with the standards accepted at the time of publication.

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Readers should confirm the information contained herein with other sources and are encouraged to consult with their health care provider before making any health care decision.
Evidence Ratings

This pathway was developed through local consensus based on published evidence and expert opinion as part of Clinical Standard Work at Seattle Children’s. Pathway teams include representatives from Medical, Subspecialty, and/or Surgical Services, Nursing, Pharmacy, Clinical Effectiveness, and other services as appropriate.

When possible, we used the GRADE method of rating evidence quality. Evidence is first assessed as to whether it is from randomized trial or cohort studies. The rating is then adjusted in the following manner (from: Guyatt G et al. J Clin Epidemiol. 2011;4:383-94.):

Quality ratings are downgraded if studies:
- Have serious limitations
- Have inconsistent results
- If evidence does not directly address clinical questions
- If estimates are imprecise OR
- If it is felt that there is substantial publication bias

Quality ratings are upgraded if it is felt that:
- The effect size is large
- If studies are designed in a way that confounding would likely underreport the magnitude of the effect OR
- If a dose-response gradient is evident

Guideline – Recommendation is from a published guideline that used methodology deemed acceptable by the team.

Expert Opinion – Our expert opinion is based on available evidence that does not meet GRADE criteria (for example, case-control studies).

Quality of Evidence:
- ★★★★★ High quality
- ★★★★★ Moderate quality
- ★★★★ Low quality
- ★★★ Low quality
- ★★ Very low quality
- ★ Guideline
- Expert Opinion
Search Methods, ED Bruising, Clinical Standard Work

Studies were identified by searching electronic databases using search strategies developed and executed by a medical librarian, Susan Klawansky. Searches were performed in June 2016 in the following databases – on the Ovid platform: Medline, Cochrane Database of Systematic Reviews, Cochrane Central Register of Controlled Trials; elsewhere – Embase, National Guideline Clearinghouse and TRIP. Retrieval was limited to 2006 to current, English language and 0-18 years of age. In Medline and Embase, appropriate Medical Subject Headings (MeSH) and Emtree headings were used respectively, along with text words, and the search strategy was adapted for other databases. Concepts searched were contusions, bruising, ecchymosis and child abuse, battered child syndrome, non-accidental injuries, unexplained injuries, inflicted trauma and other related terms. Retrieval was further limited to certain evidence categories, such as relevant publication types, Clinical Queries, index terms for study types and other similar limits.

Susan Klawansky, MLS, AHIP
September 21, 2016

Identification

139 records identified through database searching 130 records excluded
0 additional records identified through other sources

Screening

139 records after duplicates removed
139 records screened

Eligibility

9 records assessed for eligibility
4 full-text articles excluded,
3 did not answer clinical question
0 did not meet quality threshold
1 outdated relative to other included study

Included

5 studies included in pathway

Flow diagram adapted from Moher D et al. BMJ 2009;339:bmj.b2535


