

Complete Summary

GUIDELINE TITLE

Evaluation of suspected child physical abuse.

BIBLIOGRAPHIC SOURCE(S)

Kellogg ND, American Academy of Pediatrics Committee on Child Abuse and Neglect. Evaluation of suspected child physical abuse. Pediatrics 2007 Jun;119(6):1232-41. [70 references] [PubMed](#)

GUIDELINE STATUS

This is the current release of the guideline.

All clinical reports and policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT
CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Child physical abuse

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Prevention
Treatment

CLINICAL SPECIALTY

Family Practice
Pediatrics

INTENDED USERS

Advanced Practice Nurses
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To provide guidance in the clinical approach to the evaluation of suspected physical abuse in children

TARGET POPULATION

Children who are suspected victims of abuse

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation

1. Medical and family history
2. Physical exam
3. Skeletal survey
4. Tests for hematologic disorders (complete blood cell count, platelets, prothrombin time, partial thromboplastin time, international normalized ratio, bleeding time)
5. Liver enzymes (aspartate aminotransferase and alanine aminotransferase)
6. Pancreatic enzyme tests (amylase and lipase)
7. Urinalysis
8. Magnetic resonance imaging (head/neck)
9. Computed tomography (head, abdomen)
10. Cardiac enzymes (troponin and creatine kinase with muscle and brain subunits)
11. Radionuclide bone scan
12. Skin biopsy for fibroblast culture and/or venous blood for DNA analysis (for suspected Osteogenesis imperfecta)
13. Complete neurological assessment
14. Bone-mineralization disorder tests (blood calcium, alkaline phosphatase, phosphorus, vitamin D, and parathyroid hormone)
15. Retinal examination by an ophthalmologist
16. Documentation of all bruising and skin injuries

Management/Treatment

1. Referral to investigative agencies
2. Referral to appropriate medical providers

3. Legal issues (physician testimony)

MAJOR OUTCOMES CONSIDERED

Incidence of physical child abuse

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Role of the Pediatrician

Although consideration of nonabusive causes of injuries may merit additional evaluation and testing, the physician is mandated by law to report suspicions of abuse and should not delay reporting pending confirmatory testing or information. In all states, the law also provides some type of immunity for good-faith reporting. Once a suspected victim is identified and further assessment and management is required, using a pediatric child abuse consultant, if available, early in this process may obviate the need for invasive or expensive testing and can help direct the pediatrician toward appropriate evaluation. The detection and diagnosis of child physical abuse depends on the clinician's ability to recognize suspicious injuries, conduct a careful and complete physical examination with judicious use of auxiliary tests, and consider whether the caregivers' explanation is supported by the characteristics of the injury or injuries and the child's developmental capabilities. The physician should also ensure that the child's immediate medical and safety needs are met. Child abuse injuries, particularly traumatic brain injuries, may result in significant long-term disabilities including learning deficits, attention-deficit/hyperactivity disorder, behavioral problems, seizures, spasticity, blindness, paralysis, and mental retardation. Continuity of care for such children is essential, especially if they are transferred to other caregivers or foster homes.

Many hospitals and communities have developed child abuse–assessment teams of pediatricians and other professionals who specialize in the assessment of suspected victims of child abuse. Such teams usually have access to additional information from law enforcement and child protective services, such as scene investigation, that may facilitate more thorough injury assessment and diagnosis. Involving such teams early in the process can ensure accurate and comprehensive assessments and information sharing among the medical and nonmedical disciplines involved and can provide for intermediate and long-term management of the child and family. Pediatricians with expertise in evaluating suspected abuse should provide training and assistance to emergency physicians and other first responders to enhance detection and appropriate referral of these patients.

Many regions do not have specialized child abuse teams but do have physicians with expertise in child abuse. Pediatricians should know which hospitals in their region have the most available expertise in the emergency evaluation of suspected child abuse. In turn, pediatricians with expertise in child abuse often act as consultants for emergency departments and child protective services. Close

collaboration is necessary, particularly for establishing how the child should be transported between facilities, who should notify child protective services, who should notify the caregiver(s) of suspected abuse and when, and whether law enforcement should be notified. For those who do not require emergent transportation by ambulance, child protective services may facilitate transportation of a suspected child victim from one facility to another, assist in notifying the caregivers and law enforcement of suspected abuse, and provide an emergent safety plan on hospital discharge or clinic dismissal.

Clinical Presentation and Settings

Infants and children are reported as suspected victims of physical abuse when 1 or more of the following occurs:

- An individual (including a professional) sees and reports a suspicious injury
- An individual witnesses an abusive event
- A caregiver observes symptoms and brings the child in for medical care but is unaware that the child has sustained an injury
- An individual asks a child if he or she has been hurt in an abusive way
- The abuser thinks the inflicted injury is severe enough to require medical attention
- The child victim discloses abuse

The clinical approach to an infant or child with possible abusive injuries is not significantly different from standard pediatric care. As with all patients, a severely injured child must be stabilized before further evaluation is undertaken. This initial evaluation may encompass a trauma response team and pediatric specialists in surgery, emergency medicine, and critical care. Careful documentation may not be possible initially and must always be secondary to resuscitation and stabilization of the patient. Once the child is stabilized, a careful and well-documented history, as always, is the most critical element of the medical evaluation. Using quotes whenever possible, the pediatrician should document descriptions of the mechanisms of injury or injuries, onset and progression of symptoms, and the child's developmental capabilities. The physical examination should include detailed documentation, either by body diagrams and/or photographs, of any concerning cutaneous findings and should include a thorough search for other signs that may suggest a nontraumatic cause. If the child is verbal, it may be helpful to gather parental and patient histories separately. If abuse is a concern after this preliminary evaluation, consultation with a child abuse pediatrician, pediatric specialist, or pediatrician experienced in this area, if available, may be helpful in determining the best way to proceed with assessment.

Medical History

The interview of parents or caregivers of infants or children who present with serious injuries may be conducted in an outpatient or inpatient setting. If the child presents to a clinic with a serious injury that requires further medical care in a specialty (e.g., orthopedics) or hospital setting, the clinician may opt to gather the minimum information to establish a need for reporting to child protective services. Any statements made by the caregiver regarding the injury should be documented accurately and completely. Once the clinician has assessed all the injuries,

including approximate ages of injuries (when possible), a careful, complete, and detailed history should be obtained from the caregivers.

Explanations that are concerning for intentional trauma include:

1. No explanation or vague explanation for a significant injury
2. An important detail of the explanation changes dramatically
3. An explanation that is inconsistent with the pattern, age, or severity of the injury or injuries
4. An explanation that is inconsistent with the child's physical and/or developmental capabilities; and
5. Different witnesses provide markedly different explanations for the injury or injuries

Information regarding the child's behavior before, during, and after the injury occurred, including feeding times and levels of responsiveness, should be gathered. Victims of significant trauma usually have observable changes in behavior. Access to caregivers and caregiver activities before, during, and after the injury occurred are also important to document. Other information that may be useful in the medical assessment of suspected physical abuse includes:

1. Past medical history (trauma, hospitalizations, congenital conditions, chronic illnesses)
2. Family history (especially of bleeding, bone disorders, and metabolic or genetic disorders)
3. Pregnancy history (wanted/unwanted, planned/unplanned, prenatal care, postnatal complications, postpartum depression, delivery in nonhospital settings)
4. Familial patterns of discipline
5. Child temperament (easy to care for or fussy child)
6. History of past abuse to child, siblings, or parents
7. Developmental history of child (language, gross motor, fine motor, psychosocial milestones)
8. Substance abuse by any caregivers or people living in the home
9. Social and financial stressors and resources; and
10. Violent interactions among other family members

Physical Examination

Physicians must also consider that unusual events, including accidents, do happen to children and may produce injuries that are not characteristically seen from accidental causes. An injury pattern is rarely pathognomonic for abuse or accident without careful consideration of the explanation provided. In addition, both inflicted and accidental injuries may be seen simultaneously in a child.

General Assessment

The child's alertness and demeanor may reflect neurologic status and degree of discomfort and pain. A thorough and complete neurologic examination must be performed. Spontaneous and symmetrical movement of all extremities should be noted, as well as any of the child's responses that indicate pain when extremities are examined and moved. Because abusive caregivers are rarely informative

regarding the injuries that have been inflicted, special care should be taken during the examination of the child's extremities and neck, which may be fractured and require immobilization until diagnostic radiographs can be performed. Evidence of spinal cord injury, such as abnormal reflexes, muscle tone, or responsiveness to tactile stimuli, should be carefully pursued.

When the child is stable, height, weight, and fronto-occipital circumference should be carefully measured and then plotted on a growth chart. Previous measurements obtained from past medical visits should also be obtained to gauge whether growth velocity has been appropriate. Plotting parameters is essential, because clinicians may miss significant growth failure in infants and children if the clinician relies only on their clinical impressions.

Evidence of neglect may be seen during the general examination of the infant or child; extensive dental caries, severe diaper dermatitis, or neglected wound care may be noted in addition to injuries that raise suspicion of abuse. Bald areas on the scalp may sometimes be seen with severe nutritional deficits or with traumatic alopecia. These findings should be differentiated from nonabusive or benign causes such as tinea capitis, alopecia areata, and occipital bald spots caused by supine positioning of young infants.

If the child can be interviewed, his or her demeanor should be noted during questioning. Some children display strong nonverbal cues of anxiety and reluctance when answering questions regarding potential abuse, because they are protective of their abuser or they fear retribution for "telling." Others may appear openly fearful of their abuser. Such responses may be important to consider when a safety plan for the child is made.

Skin Injuries

Location, size, and shape of any bruises, lacerations, burns, bites, or other skin injuries should be documented in a medical chart as well as with high-quality 35-mm or digital photographs. Inspection for injuries should be thorough and involve all aspects of the neck and head; mouth; extremities, including feet and hands; genitals; anus; buttocks; torso; and back. Obscure sites for inflicted injuries include the ears, especially the posterior aspects, the neck and angle of the jaw, scalp, and the frenula of the lip and tongue. In contrast to accidental injuries, inflicted injuries tend to occur on surfaces away from bony prominences, such as the neck, head, buttocks, trunk, hands, and upper arms. Hematomas of the scalp may be detected through palpation or may be visualized on radiographs. Some deeper bruises may not be readily visible for several hours; areas that are painful to palpate may require further examination in 1 to 2 days, when bruises may become apparent. Measurement of skin injuries may assist in determining the mechanism of injury and/or object used to inflict the injury.

Bite marks can yield important forensic information; referral to professionals that can gather such information and maintain a chain of custody is advisable. Bite marks, recent or healed, should be carefully measured and photodocumented when possible; an intercanine distance of more than 2 cm suggests a human adult-sized bite. In some facilities, forensic odontologists are available and may use special examination and photographic techniques to analyze bite marks. Fresh

bites should be swabbed with sterile, premoistened cotton-tipped applicators for forensic analysis of potential genetic markers found in saliva.

Burn injuries may be chemical, thermal (including exposure to scalding liquids or hot objects), or electrical. The child's clothing worn during the burn should be collected and may provide information regarding the cause of the burn. Burns inflicted with hot objects can be difficult to differentiate from accidental mechanisms, because both burns may be patterned. The history, number of burns, and continuity of the burn pattern over curved body surfaces may indicate a greater probability of inflicted trauma. Accidental scalds most commonly involve hot liquids pulled or splashed onto the child's upper extremities, torso, and or neck and head. Inflicted scalds or forced-immersion burns may be well demarcated in pattern, with few or no splash marks. When evaluating an apparent burn injury, other noninflicted causes to consider include chemical burns of the buttocks with senna-containing laxatives, bullous impetigo, and accidents.

Cranial Injuries

Infants with intracranial injuries frequently have no or nonspecific symptoms, so the absence of neurologic symptoms should not exclude the need for imaging. Careful consideration of symptoms, signs, history, and judicious use of other ancillary tests should guide the clinician in determining the need for imaging.

Abuse should be suspected when there is a history of minor head trauma such as a short fall in children with multiple, complex, diastatic, or occipital skull fractures. Whenever an infant or child presents with a skull fracture, care should be taken to ensure that there are no other injuries.

A fundoscopic examination for retinal hemorrhages should be considered for any infant or young child who is a suspected victim of physical abuse. Under optimal conditions, an ophthalmologist with pediatric experience should conduct an examination of dilated pupils by using indirect ophthalmoscopy. The ophthalmologist should provide documentation of the retinal hemorrhages by photography or detailed annotated drawings. Location, depth, and extent of retinal hemorrhages may distinguish between abusive and nonabusive causes of head trauma.

Thoracoabdominal Injuries

Auscultation, performed before palpation, may reveal decreased or no bowel sounds if the child has sustained intraabdominal injury. If the intestines, liver, or spleen have been ruptured, guarding or abdominal muscle rigidity may be noted on palpation. Abdominal bruising is often not seen, even with severe blows to the abdomen. Liver and pancreatic enzyme tests are helpful in screening children for abdominal trauma, especially when the child presents with acute symptoms or shortly after the incident has occurred. A urinalysis may also lead to the discovery of unexpected trauma to the urinary tract and kidneys. Radiographic studies, including computed tomography, are helpful in determining the types and severity of intraabdominal trauma and are warranted in most cases when the physical examination is unreliable because of patient age, presence of other injuries that may obfuscate the abdominal examination, or the presence of head injury.

Skeletal Injuries

Careful palpation of the legs, arms, feet, hands, ribs, and head may reveal acute or healing (callus formation) fractures. If a fracture is suspected, surfaces should be carefully examined for "grab marks" that may indicate restraint or areas that were pulled or twisted to create the fracture; however, absence of such bruising does not exclude abusive mechanisms of injury. Soft tissue swelling, with or without bruising, may indicate more recent trauma. Many fractures, including rib and metaphyseal fractures, may not be clinically detectable, so a negative clinical examination should not preclude the need for a skeletal radiologic survey when inflicted trauma is suspected, particularly in children younger than 2 years.

Long-bone fractures that should be evaluated carefully for nonaccidental causes include metaphyseal fractures and spiral/oblique fractures, especially in nonambulatory infants; both types of fractures have been associated with accidental mechanisms of injury as well.

A complete neurologic assessment, including reflexes, cranial nerves, sensorium, gross motor, and fine motor abilities, should be conducted. Abnormalities may reflect current or past injuries to the central nervous system. Abused children may also have developmental disabilities because of deprivation in the home environment or other causes.

Diagnostic Testing and Consultations

When abuse is suspected as the cause of an injury, the clinician may conduct tests to screen for other injuries or underlying medical causes for the injury. The extent of diagnostic testing depends on several factors including the severity of the injury, the type of injury, the age of the child, and examination findings. In general, the more severe the injury and younger the child, the more extensive is the need for diagnostic testing for other injuries. The Table below is a summary of tests, some of which may be used during a medical assessment for suspected abuse.

When one child is identified as a suspected victim of abuse, siblings and other child contacts of the suspected abuser should also be assessed for injuries. The extent of the assessment depends on the child's age, symptoms, and signs; infants and toddlers may require more extensive testing, because symptoms and signs may be less useful in determining the presence of occult inflicted injuries.

Table. Diagnostic Tests That May Be Used in the Medical Assessment of Suspected Physical Abuse and Differential Diagnoses

Type of Injury or Condition	Diagnostic Tests	Comments
Fractures	Skeletal survey: humeri, forearms, femurs, lower legs, hands, feet, skull, cervical spine, thorax (including oblique views) and lumbar spine, pelvis	<ol style="list-style-type: none">1. Recommended for all children with fractures and children with any suspicious injuries under age 22. Repeat skeletal survey in 2 weeks for high-risk cases

Type of Injury or Condition	Diagnostic Tests	Comments
		3. Single whole-body films are unacceptable
Bruises	Tests for hematologic disorders: CBC count, platelets, prothrombin time, partial thromboplastin time, INR, bleeding time; additional testing (e.g., factor levels) may be indicated after initial screening tests	<ol style="list-style-type: none"> 1. Recommended when bleeding disorder is a concern because of clinical presentation or family history 2. A DIC screen should be performed for patients with intracranial injury, because intraparenchymal damage can alter coagulation 3. PFa-100: platelet function activity is preferable to bleeding time for establishing platelet function but is not widely available
Liver Injury	Liver enzyme tests: aspartate aminotransferase and alanine aminotransferase	<ol style="list-style-type: none"> 1. May be helpful in diagnosing occult hepatic injury
Pancreatic injury, pseudocyst	Pancreatic enzymes: amylase and lipase	
Urinary system/renal injury	Urinalysis	
Intracranial and extracranial injury	MRI: head/neck	<ol style="list-style-type: none"> 1. Diffusion-weighted scan may surpass CT in characterizing extent of intercerebral edema 2. May provide better dating of intracranial injuries than CT 3. More sensitive than CT for subtle intracranial injuries in patients with normal CT results and abnormal neurologic exams 4. More sensitive than plain radiographs and CT for detecting cervical spine fractures/injury
Intracranial and	CT scan: head ^a	<ol style="list-style-type: none"> 1. When used in conjunction

Type of Injury or Condition	Diagnostic Tests	Comments
extracranial injury		with radiographs, may enhance detection of skull fractures
Intracranial injury	Urine: organic acids	1. Screen for glutaric aciduria type 1
Intra-abdominal injuries	CT scan: abdomen	1. IV contrast should be used and is preferable to PO
Cardiac injury	Cardiac enzymes: troponin and creatine kinase with muscle and brain subunits (CK-MB)	
Skeletal	Radionuclide bone scan	1. Better for acute rib fractures and subtle, nondisplaced long-bone fractures
Osteogenesis imperfecta	Skin biopsy for fibroblast culture and/or venous blood for DNA analysis	
Bone-mineralization disorders: rickets	Calcium, alkaline phosphatase, phosphorus, vitamin D, and parathyroid hormone	

Tests should be ordered judiciously and in consultation with the appropriate genetics, hematology, radiology, and child abuse specialists. Careful consideration of the patient's history, age, and clinical findings should guide selection of the appropriate tests. CBC indicates complete blood cell; INR, international normalized ratio; DIC, disseminated intravascular coagulation; CT, computed tomography; IV, intravenous; PO, oral; CK-MB, creatine kinase MB band.

^aCT scanning may provide clinically relevant information more expeditiously than MRI in some facilities.

Documentation and Diagnostic Considerations

Complete documentation of visible injuries on body diagrams and with photographs is strongly urged and facilitates peer review as well as court testimony, when required. Diagnostic impressions should address whether the explanation adequately correlates with the severity, age, pattern, and distribution of the injury or injuries and the likelihood of nonaccidental causes for the injury. If a child has sustained a serious injury because he or she was left unsupervised in a dangerous environment, the physician should report suspected neglect or inappropriate adult supervision, including injuries sustained while under the care of an intoxicated adult, to child protective services. When the child is evaluated or tested for other nonabusive causes, documentation should reflect the results of this assessment as well. In general, concern for abuse is greatest for infants younger than 12 months regardless of the severity of the injury.

Treatment

Once medical assessment and stabilization are achieved and a referral has been made to investigative agencies, the physician should ensure that the child receives the necessary follow-up services. The child's primary care physician should be notified, and child protective services should ensure that the family complies with the plan of care. These services should not only include referral to appropriate medical providers but also address the psychological effects of abuse or neglect on the young child, the siblings, and the nonoffending caregiver. Because adult-partner violence commonly co-occurs with child abuse, several family members may require medical and mental health assistance. Medical passports, which are abbreviated medical chart forms usually kept by foster parents and presented at each medical visit, are recommended to optimize treatment regimens in children who are shifted among agencies and individuals during the course of the child abuse investigation.

Legal Issues

All 50 states have statutes that mandate reporting of suspected child abuse and neglect; the physician is not required to prove abuse before reporting. Familiarity with state laws will ensure that physicians report to the appropriate agency within the required time frame; some states have provided the option of making such a report through the Internet. Information on specific state laws are provided by the Children's Bureau (Administration for Children and Families, US Department of Health and Human Services; see http://www.childwelfare.gov/systemwide/laws_policies/). Many states have laws that permit physicians to evaluate children who are suspected victims of abuse, to conduct tests, and to take photographs without parental consent.

The physician may be required to write a sworn statement of his or her findings and to testify in civil or criminal trial proceedings. Physicians are expected to testify to the facts on the basis of their knowledge and experience in pediatrics and, when appropriate, in child abuse. As such, they may be asked to render opinions regarding the normal developmental capabilities of children at certain ages as well as the mechanisms of injury, severity of the injury, and prognosis. Pediatricians should not testify to anything that is beyond their level of knowledge or expertise.

Conclusions

Child physical abuse is a common problem of childhood. The physician must be able to recognize suspicious injuries, conduct a comprehensive and careful examination with appropriate auxiliary tests, critically assess the explanation provided for the injury or injuries, and establish the probability that the explanation does or does not correlate with the pattern, severity, and/or age of the injury or injuries. The physician is responsible for reporting suspected abuse, documenting his or her opinions clearly, and providing the necessary information and expertise to investigative and legal personnel and parents, when appropriate. In addition, pediatricians are uniquely qualified to work with parents and caregivers to prevent abuse by providing anticipatory guidance on normal child behavior and its management. Finally, physicians must advocate that children in foster care who have medical or mental health problems receive the appropriate

services and medications and continuity of care through a medical home, and that a medical passport is maintained for these children.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting each recommendation is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Accurate and timely diagnosis of children who are suspected victims of abuse can ensure appropriate evaluation, investigation, and outcomes for these children and their families

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

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2007 Jun

GUIDELINE DEVELOPER(S)

American Academy of Pediatrics - Medical Specialty Society

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American Academy of Pediatrics

GUIDELINE COMMITTEE

Committee on Child Abuse and Neglect

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Committee on Child Abuse and Neglect, 2006-2007: Carole Jenny, MD, MBA, *Chairperson*; Cindy W. Christina, MD; Roberta A. Hibbard, MD; Nancy D. Kellogg, MD; Betty S. Spivack, MD; John Stirling, Jr, MD

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

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GUIDELINE AVAILABILITY

Electronic copies: Available from the [American Academy of Pediatrics \(AAP\) Policy Web site](#).

Print copies: Available from American Academy of Pediatrics, 141 Northwest Point Blvd., P.O. Box 927, Elk Grove Village, IL 60009-0927.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

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