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EVIDENCE-BASED PRACTICE RECOMMENDATIONS

An Evidence-Based Review Of Medical Child Abuse In The ED

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The pediatric ED setting can often become quite hectic, with clinical presentations ranging from the pedestrian-versus-motor vehicle accident to the overanxious mother worried about an infant who will not stop crying. But what does one do when a parent's chief complaint is out of proportion to the child's physical examination? In cases such as these, medical child abuse (MCA) should be considered in the differential diagnosis. Medical child abuse has been known by many names over the years, including Münchausen syndrome by proxy (MSBP), factitious disorder by proxy (FDBP), and most recently, pediatric condition falsification (PCF).[2] For a more detailed and systematic look at medical child abuse, see the full text article at www.ebmedicine.net.

Key Points	Comments
Keep MCA in the differential when patients present with atypical signs and symptoms, when diagnosis is illusive, or when the patient does not respond to the usual course of treatment.	Victims usually present with an apparent recurring illness that cannot be easily explained by the physicians consulted, despite extensive medical work ups. Often, illnesses present in very atypical patterns. Diagnosis may point toward a very rare disorder. Symptoms often do not respond to the usual treatments. Laboratory and clinical findings may not match up with the clinical presentation or history or may be physiologically impossible. Physically, the child may appear to be very healthy and may not reflect the symptoms reported by the parent.[7]
Above all, remain objective.	Do not get caught up in the medical knowledge of the parent. Do not develop a close relationship with the parent apart from trying to help diagnose whatever is wrong with the patient. It may be difficult at times to distinguish those parents who simply disagree with the treatment approach of their child's physician.[6] Of note, the parent of the chronically ill, non abused child is also very medically savvy. She knows the system, can verbalize her concerns, and has her child's best interests in mind.
Review all past records. Delve into various institutions. Contact child protective services and/or the police according to local reporting requirements.	You may need to report the case to appropriate authorities first to do this, unless a parent willingly signs consent without suspecting investigation. Confirm all test results. Discuss them with previous providers and preferred medical doctor to get a better sense of the interactions with the caretaker and any perceptions of a diagnosis that may not be recorded in the medical record.
Remember that communication is key, particularly within the multidisciplinary team as a whole.	Working alone will often leave the physician feeling overwhelmed and without a tangible diagnosis. The members of the medical team should include physicians (especially those who specialize in the area of child abuse), social workers, nurses (who serve as the front line in contacts with the mother and child), hospital administrators (because investigative steps such as covert video surveillance [CVS] may involve certain repercussions to the hospital), a legal consultant, and hospital security personnel (often used to confront the deception and for monitoring CVS). Other desirable, but optional, members of this team include any subspecialists who are involved in the care of the patient and a psychiatrist, both for the patient and the parent.[18]
Document, document, document! Nursing and ancillary staffs that frequent the bedside of the child are critical to this effort.	The team must gather the necessary information and medical records on the child's care, looking specifically at ongoing records of the child's recurring symptoms or response to treatment to see if they match the mother's reports.
When the team is finally ready to approach the family with the diagnosis, the number of people involved should be limited.	The case should be stated clearly and simply, and the mother should be informed that the case has been reported to social services. The most important approach is to remain supportive but not accusatory. The team should also be prepared to provide for the immediate protection of the child. Obtaining a court hold on the child is essential. Child protective services is responsible for making sure of the safe placement of the child. Returning the child to the care of the non offending caregiver may not be effective.

See reverse side for reference citations.

REFERENCES

These references are excerpted from the original manuscript. For additional references and information on this topic, see the full text article at ebmedicine.net.

2. Stirling J; American Academy of Pediatrics Committee on Child Abuse and Neglect. Beyond Münchausen syndrome by proxy: identification and treatment of child abuse in a medical setting. *Pediatrics*. 2007;119(5):1026-1030. **(Literature review)**

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