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Narrative Review

How to Manage Suspected Child Abuse

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Sexual abuse,
Maltreatment,
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ABSTRACT

The skin is the organ most frequently exhibiting signs that may raise suspicion of abuse. For this reason, dermatologists and pediatricians are often called upon to assess whether certain cutaneous lesions are indicative of a dermatological condition or suggest the possibility of abuse. Resolving this diagnostic uncertainty is not always straightforward. Therefore, it is essential that both dermatologists and pediatricians possess thorough knowledge of dermatological disorders that may mimic signs of abuse. The author will describe some of the most frequent and clinically significant conditions.

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Introduction

Child abuse and neglect, as defined by the World Health Organization (WHO), include physical, emotional, and sexual abuse, as well as neglect and exploitation. These forms of maltreatment endanger the child's health, development, and dignity.

Unfortunately, most statistics show that in approximately 80% of cases, the perpetrators are the parents themselves. Abuse may take various forms: neglect, physical and sexual maltreatment, emotional abuse, and Munchausen Syndrome by Proxy.

Physical and sexual abuse often result in the appearance of skin lesions. The skin is, in fact, the organ that most readily shows signs that may raise suspicion of abuse, followed by bone fractures and injuries to soft tissues and internal organs. For this reason, dermatologists and pediatricians may be called upon to assess whether certain skin lesions are indicative of a dermatological condition or suggest the possibility of abuse. In some clinical scenarios, resolving this uncertainty may not be straightforward, which is why dermatologists and pediatricians must have thorough knowledge of all dermatological diseases that can mimic signs of abuse (1).

Ecchymotic lesions

Since these skin manifestations often result from accidental trauma, the suspicion of abuse arises not only from the type of lesion but especially from its location. When ecchymotic lesions (hematomas or bruises) appear in areas of the body that are less exposed to accidental trauma - such as the neck, nape, ears, genital regions, buttocks, and flexural areas of the limbs - physical abuse must be considered (2). However, it is not uncommon for children to sustain traumatic ecchymotic or ulcerative lesions in the genital and perigenital regions. In such cases, a thorough history is invaluable when it provides a credible reconstruction of the events. Regarding lesion location, it should be noted that non-traumatic ecchymotic lesions may also be found bilaterally in the orbital regions in cases of juvenile dermatomyositis, and unilaterally in cases of ophthalmic herpes zoster (Fig. 1).

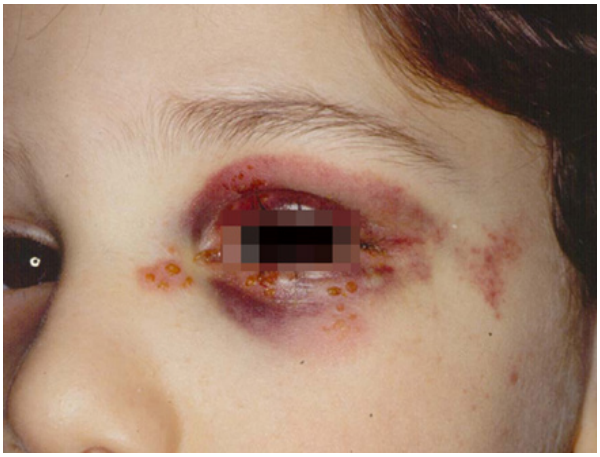

Fig. 1. *Ophthalmic herpes zoster.*

Figurative Lesions

The configuration of skin lesions often suggests their possible origin. This is evident, for example, in cases of ecchymotic lesions that reproduce the shape of a hand (slaps), a bite, or a belt used for whipping (3). Linear-patterned lesions may also be observed in various dermatological conditions, such as certain phytophotodermatitis (Fig. 2), urticarial dermographism, or contact with jellyfish. Patterned lesions resulting from ethnic rituals should also be considered – for instance, cupping (Fig. 3), an ancient therapeutic practice involving the application of cups to the skin to create suction. This is believed to stimulate blood circulation, promote muscle relaxation, and help reduce pain and inflammation. Other similar ritual practices capable of producing patterned skin lesions include Cambodian Cao Gao and Moxibustion, a technique widespread in

Southeast Asia.

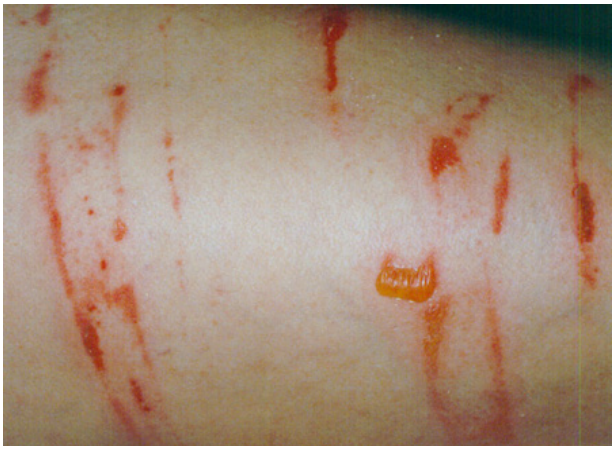

Fig. 2. *Phytophotodermatitis of the leg due to contact with asteraceae.*

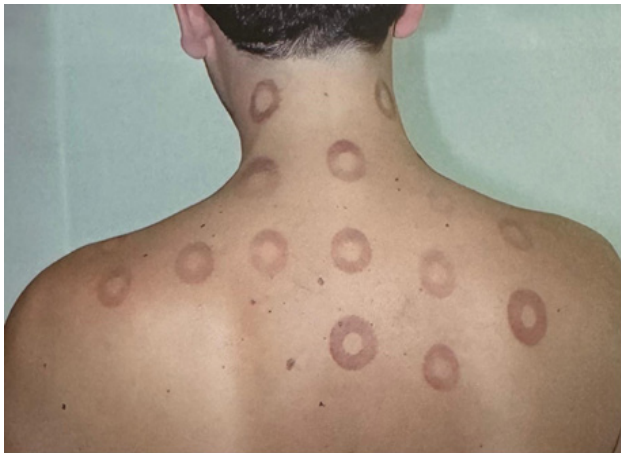

Fig. 3. *Cupping.*

Excoriated Lesions

Excoriated skin lesions are rarely a reason to suspect physical violence, as they are commonly found in numerous dermatological conditions - particularly those associated with itching, such as eczema or scabies. However, when these lesions are patterned or appear in unusual distributions, they may suggest a diagnosis of dermatological factitious disorder (Fig. 4). In such cases, a gentle yet thorough medical history is essential, as these lesions are not always self-inflicted. Occasionally, they may be caused by a family member, pointing to a case of Munchausen Syndrome by Proxy, which constitutes a form of abuse.

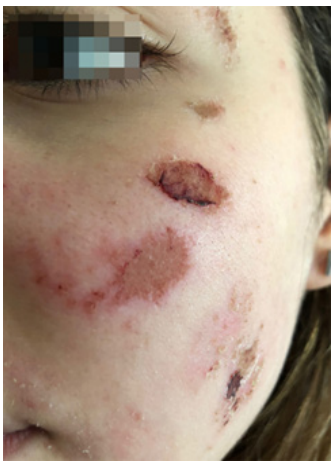

Fig. 4. *Self-inflicted injuries.*

Burns

Wounds and burns with a rounded shape and approximately 1 cm in diameter - especially when located on exposed areas - inevitably raise suspicion of intentional injury, such as cigarette extinguishing. Clearly identifiable scalds on the face, chest, abdomen, and upper limbs are often the result of accidental contact with overheated liquids, typically spilled during meal preparation. However, immersion scalds, symmetrically located on the buttocks, lower limbs, or hands and feet in young children, warrant particular attention, as they may indicate abuse. It is also important to consider pathological conditions that can mimic superficial dermal burns, such as Staphylococcal Scalded Skin Syndrome (SSSS) - caused by bacterial toxins - and Toxic Epidermal Necrolysis (TEN) - triggered by medications (Fig. 5). In these cases, accompanying symptoms and mucosal involvement are key to establishing a differential diagnosis.

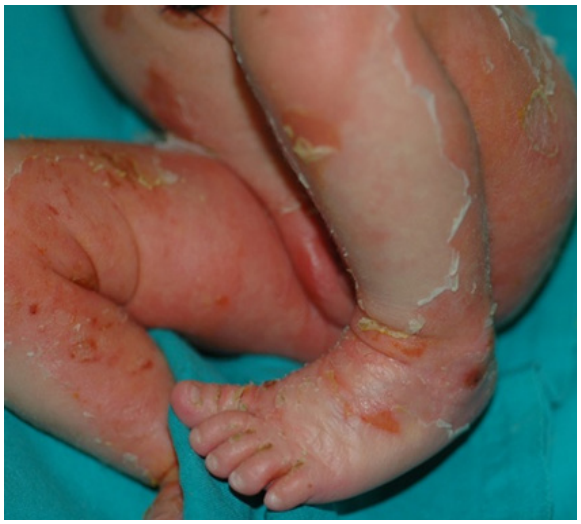

Fig. 5. *Staphylococcal Scalded Skin Syndrome (SSSS).*

Genital Region Lesions

These situations are generally difficult to interpret. This applies to traumatic lesions, which are more often accidental but may also result from mistreatment or even sexual abuse. It also applies to dermatological conditions potentially transmissible through sexual contact, such as genital warts and herpes simplex. Determining the cause of anogenital warts in children can be difficult, as the human papillomavirus (HPV) can infect children through various routes. In the case of anogenital warts occurring before the age of four, vertical transmission (prenatal or perinatal) or horizontal transmission (self-inoculation or inoculation by adults with hand warts) is more likely (4, 5). It is much less common for genital herpes to be transmitted through non-sexual means.

In young girls, innocent vulvovaginitis is not uncommon. In such cases, the integrity of the hymen - while not absolutely excluding the possibility of sexual abuse - certainly serves as an indicator in favor of innocence. Vulvar (and perianal) lesions most often mistakenly interpreted as signs of abuse are those attributable to lichen sclerosus et atrophicus (6), a skin condition that is readily identifiable by its atrophic, sclerotic appearance, whitish lard-like patches, the presence of an inflammatory halo during active phases (Fig. 6), and - most notably - persistent itching.

Other conditions that may mimic signs of abuse include streptococcal perianitis, pyramidal perianal protrusion, idiopathic scrotal edema, and perianal epidermal nevus.

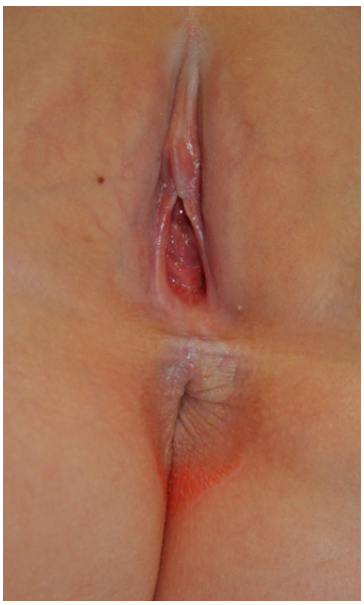

Fig. 6. *Vulvar and perianal lichen sclerosus et atrophicus.*

Conclusions

It is not always easy to correctly assess cases involving ecchymotic lesions, wounds or abrasions, unusual burns, potentially sexually transmitted lesions, and especially any type of injury located in the genital and perigenital regions. Great care must be taken to distinguish pathological conditions from direct signs of abuse. However, in any situation where suspicion is justified, it is a duty to report the matter to the Judicial Authority, which will then initiate appropriate investigations and make decisions accordingly.

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