Fractures and Child Abuse
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I do not have any relevant financial interests with any commercial entities.

CME DISCLAIMER

OBJECTIVES
- Describe types of fractures seen in child abuse
- Review basic mechanisms of injuries
- Describe management plans to evaluate for fractures
ABUSE AND FRACTURES

- Up to one third of abused children are diagnosed with fractures.
- Fractures are often occult or the diagnosis is missed, particularly in younger children that are not walking or talking.
- Fractures are a very common accidental injury.
- Some fractures and fracture features are more commonly observed in abusive situations.
- Some fractures rarely occur accidentally.
- Any type of fracture can occur due to child abuse.

CASE

- A 7 week old presented to his primary care doctor with evidence of a bruise under his right eye.
- He had been seen (ED) 3 days prior to this visit for blood in his diaper and was found to have a normal examination. Parents were also concerned about the shape of his head, ultimately diagnosed as plagiocephaly.
- He had been left in the care of his father while the mother worked during the day.
- The father said that the fall was unwitnessed and occurred one week ago.
- The father had put the baby on the couch and momentarily went to another room, heard a thump and found him on the carpeted floor.
A complete evaluation in suspected physical abuse includes obtaining a complete history, physical, lab work, reporting and child abuse pediatrician consultation when needed.

http://champprogram.com/resources.shtml


**IMAGING PROTOCOL**

**Subdural Hemorrhage**

- The finding of apnea and/or retinal hemorrhage in a child with brain injury is more strongly associated with iTBI than with nTBI.

Subdural Hemorrhage
MECHANISMS OF ABUSIVE HEAD TRAUMA

- Moving head strikes stationary object.
- Stationary head hit by a moving object.
- Both head and object colliding.
- Direct vs. Indirect Injury
  - Parenchymal brain injury
  - Secondary brain injury

SHORT FALLS
Serious injuries attributed to a fall from a low height are unlikely and in most instances due to child abuse.

- Helfer, 1977, 246 short falls, 85 in the hospital
- Nimityongskul, 1987, 76 hospital falls
- Williams, 1991, 44 falls
- Lyons, 1993, 124 cribs, 83 beds
- Chiavello, 1994, stairway falls
- Chadwick, 1991...

THE “OTHER” POSSIBILITIES

- Subdural collections occur without trauma.
  - “Statistics don’t matter - you’re going to see the one in a million or billion or whatever at some time, and why can’t this kid right here be the one.”
- Glutaric aciduria Type I
- Rebleeds (from birth trauma)
- Primary brainstem damage leading to an anoxic event (Geddes)
RETINAL HEMORRHAGES

- Retinal hemorrhages are a cardinal manifestation of abusive head trauma.
- May be a few, exclusively intra-retinal, confined to the posterior pole, or microscopic (seen at autopsy only).
- Asymmetry and unilaterality are well recognized.
- Traumatic retinoschisis may occur.

Accidental retinal hemorrhages

- Studies estimate these can occur in less than 3% of accidental head traumas.
- Almost always following significant trauma by history.
- Vaginal birth
  - Superficial (splinter) hemorrhages resolve within one week.
  - Deeper hemorrhages (dot blot) resolve within 6 weeks.


Huges et al. Incidence distribution and duration of birth-related RH. J AAPOS. 2006
RETINAL HEMORRHAGES

- CPR (6 studies, one prospective, 1 multicenter)—RH rarely occur from CPR. When they do, they are few and confined to the posterior pole.
- Increased ICP: Seen with central retinal vein occlusion and papilledema. No evidence that increased ICP causes RH in SBS.

WHEN TO SUSPECT ABUSIVE FRACTURES

- An inconsistent or inadequate history is provided, particularly if the mechanism of trauma is not consistent with the finding.
- Child is developmentally unable to cause the injury to self.
- Unexplained or poorly explained delay in seeking medical care.
- Associated injuries with poor explanation(s).
- Absence of radiologic (and serologic, if testing performed) evidence of bone disease.
- Confession of intentional trauma or witnessed event.
- Other signs or symptoms of abuse in a child less than 2 years.

EVALUATION OF FRACTURES

- A detailed history (how, when, what, where and witnesses)
- A clear developmental history
- Past medical history (past injuries)/family history
- Scene evaluation: pictures and measurements
- Skeletal survey (when indicated)
- CT and/or bone scan may complement evaluation
- Consider Vitamin D or other assessment for bone demineralization or pathology
- Family history of fractures, mother’s dietary intake during pregnancy, family history of bad teeth
SKELETAL SURVEY

- Recommended in situations of suspected child abuse in children under the age of 2 years.
- Most recommend oblique rib radiographs (not shown on this table).
- REPEAT SKELETAL SURVEY IN 2 WEEKS.


Rib fractures may not be apparent on plain films and bone scintigraphy (bone scan) is sometimes indicated. Follow-up skeletal survey is recommended in 2 weeks as an alternative to bone scan.
The optimal yield of occult fractures is in children under 2 years of age... and older kids with disabilities.

Either SS or BS gives information on the age of injuries; SS or BS alone will miss occult fractures.

BS may miss skull fractures, metaphyseal and epiphyseal fractures.

Oblique views of the ribs increase the diagnostic yield of rib fractures in a SS.

Repeat SS (1-2 weeks later) increases the identification rate of fracture.

COMMONLY MISSED FRACTURES

- Acute rib fractures
- Pelvic fractures (pubic rami)
- Vertebral fractures, spinal fractures and dislocations
- Metaphyseal fractures
- Skull fractures, especially if only CT is performed
- Fractures of the hands and feet

MULTIPLE UNEXPLAINED FRACTURES

- Head injury, including fracture
- Rib fractures
- Radius fracture
- Vertebral fracture

- Other:
  - Retinal hemorrhages
  - History of rectal bleeding

MOST COMMON ABUSIVE FRACTURES

- The most common fractures in abused children involve the skull, long bones and ribs. The numbers vary (relatively) depending on the series studied (detail of radiologic imaging), age of the children and whether the studied populations included fatalities.
CASE Fractures
- Skull fracture
- Radial fracture
- Rib fractures
- Vertebral body fracture

POTENTIAL DIFFERENTIAL DIAGNOSIS OF MULTIPLE FRACTURES: HIGHLIGHTS FROM THE AAP CLINICAL REPORT

- Child abuse
- Osteogenesis Imperfecta: Not all OI have classic findings
- Premature birth—osteopenia
- Rickets—Vitamin D deficiency
- Osteomyelitis
- Copper deficiency
- Paralysis (demineralization)
- Rare conditions

COMPLEX OR SIMPLE?
Moderate Specificity: Complex Skull Fractures

- Simple: A single fracture that extends in a straight, curved or linear fashion. The fracture margins are separated by less than 3mm. They are restricted to a single bone.
- Complex: Consist of more than one fracture line. May have a stellate or branching pattern. May cross suture lines.
- Compound: There is a skull fracture with an overlying laceration of the scalp.


Most common fracture in both abused and non-abused children.

CT reconstruction may assist with determination of fractures. In this case there is a finding of a depressed fracture that was not as evident on the skull films.
FIG. 4.
Fracture Patterns in Children and Young Adults Who Fall from Significant Heights.
Sawyer, Jeffrey; Flynn, John; Dormans, John; Catiel, John; Drummond, Denis.

Mechanism of trauma

Scene investigation

MODERATE SPECIFICITY: COMPLEX SKULL FRACTURES


COMPLEX
HIGH SPECIFICITY FOR ABUSE: RIB FRACTURES

- Relatively commonly caused by abuse.
- Can be occult.
- 90% seen < 2 years of age.
- Rib fractures from abuse can be seen in any location along the rib and may be unilateral or bilateral.
- Posterior rib fractures are most commonly due to levering action and involve either:
  - Rib head: costo-vertebral articulation
  - Rib neck: costo-transverse process articulation

RIB FRACTURES: MECHANISM OF TRAUMA

- Squeezing
- Rotation of the ribs posteriorly with squeezing action
- Crush injury
- Direct trauma to thoracic area
- Bone disease and trauma to the chest

RIB FRACTURES: CAUSES

- Uncommon with birth trauma.
- Not likely from cardiopulmonary resuscitation, especially posterior rib fractures (has been reported with 2-handed CPR).
- Generally compressive forces, not direct blows (has been reported after Chest Physiotherapy).
- Seldom see overlying bruises.
- After fractures, infant may be asymptomatic.
RIB FRACTURES AND OVERLYING BRUISES: AN UNCOMMON FINDING

In a case control study of 71 bruised patients admitted to a PICU with either accidental or non-accidental trauma, 33 were abused and 38 admitted due to accidental trauma. Characteristics predictive of abuse were bruising to the chest, torso, ear or neck for a child less than 4 or bruising anywhere on a child less than 1 year.

THE ABSENCE OF BRUISING

In the Peters study of 192 children (6 weeks to 120 months) with inflicted fractures (626 fractures) no bruising was found in 57.8% of the study participants. 20.8% had bruising near the site of at least one fracture. Of these, 43.3% were skull fractures with bruising or associated subgaleal hematomas. The presence of bruising near the site of an extremity or rib fracture was an uncommon finding.

NOT EVERYONE AGREES...

http://www.bailii.org/ew/cases/EWHC/Fam/1994/5.html

CASE: VERTEBRAL FRACTURES

Mechanism is usually compression of the spine.
Often missed on infant or child X-rays.
Can result in spine deformities.
Does not show up well on bone scan.

http://www.champprogram.com/question/5.shtml

CASE: MODERATE SPECIFICITY: VERTEBRAL FRACTURES

CASE: LONG BONE FRACTURE
TYPES OF LONG BONE FRACTURES

For more information and diagrams depicting long bone fractures see:
http://childabusemed.com/appendices/appendix-F.shtml

LONG BONE FRACTURES

- "Is the fracture morphology consistent with the direction, magnitude and rate of loading described by the mechanism?"
- What is the child’s developmental capability and could the child have generated the necessary energy, independent of the "outside" forces, to cause the observed injury?
- Did the event generate enough energy to cause this fracture?
- Were there structural factors of the bone itself that contributed to the likelihood of fracture?

HIGH SPECIFICITY FRACTURES: CLASSIC METAPHYSEAL LESIONS

- There is minimal or no periosteal disruption or reaction.
- Shearing forces disrupt the immature mineralized bone and not the adjacent cartilaginous physes.
- Bone scan should not be used to diagnose CMLs.

MECHANISM OF TRAUMA FOR CMLS

- Requires shearing forces not generally produced in accidental trauma.
- Possibly produced during shaking when limbs flail.
- Also consider twisting, jerking or pulling mechanisms.

OUR CASE

- 7 week old
- Multiple fractures
- Head trauma with SDH and RH
- No CMLs
- Minimal bruising
- History not consistent with findings

POTENTIAL DIFFERENTIAL DIAGNOSIS OF MULTIPLE FRACTURES: THE DEFENSE ATTORNEY’S DREAM

- Infant has Osteogenesis Imperfecta.
- Infant was breast fed and his skin is pigmented, so he likely is Vitamin D deficient, therefore, more likely to fracture.
- Infant probably has temporary brittle bone disease.
OSTEOGENESIS IMPERFECTA

- There are now at least 8 identified types of OI.
- Clinical features overlap of some.
- Not all have blue sclera.
- Type II (perinatal) is lethal.
- Type III, VII, VIII are severe phenotypes. DI may be present.
- Hearing loss is later onset.
- Type I may have normal stature, normal appearing bones, and fractures. Hearing loss is a feature.

HISTORY FOR OI

- Short stature or stature shorter than predicted based on stature of unaffected family members, often with bone deformity
- Blue sclera
- Dentinogenesis imperfecta (smile, mom!)
- Progressive, postpubertal hearing loss (family members or patient)
- Ligamentous laxity and other signs of connective tissue abnormality (in family members or patient)
- Family history of OI, usually consistent with autosomal dominant inheritance
AREAS OF OVERLAP OF OI AND ABUSE

- Fractures of varying ages and stages of healing, often of the long bones but may also involve ribs and skull.
- The metaphyseal chip fractures characteristic of child physical abuse can be seen in a small number of children with OI.
- "Codfish" vertebrae, which are the consequence of spinal compression fractures, seen primarily in the adult.
- Wormian bones, defined as "sutural bones that are 6 mm by 4 mm (in diameter) or larger, in excess of 10 in number, with a tendency to arrangement in a mosaic pattern."
- Wormian bones are suggestive of, but not pathognomonic, for OI.
  They are present in up to 60% of affected children.

OSTEOSTENESIS IMPERFECTA

![Image of a child's eye and bone structures]
OUR CASE

- No FH of OI
- No FH of short stature, easy bruising or fractures or bad teeth
- No other siblings
- No triangular face, no blue sclera
- Birth history was negative for trauma...
- FT baby (not premature birth)
- No wormian bones

REASONABLE DOUBT?
WHAT ABOUT VITAMIN D DEFICIENCY?

- Cholecalciferol is to increase the efficiency of calcium absorption from the small intestine.
- Phosphorus absorption is important for proper mineralization of bone.
- The second major function of cholecalciferol is for the maturation of osteoclasts to resorb calcium from the bones.

Chapman, et al.: Rickets

- 45 children (2-24 months), with only 4 younger than 7 months.
- The majority (32 had nutritional rickets), the rest were metabolic causes or secondary to other diseases.
- 40 children were included in the data (2 had elevated alk phos only, 3 with unknown causes of rickets were excluded, none of these had fractures).
- 7 children had fractures and all 7 had nutritional rickets.
- All 7 were mobile.
- All 7 had widespread rachitic changes.
- Fractures were all considered structural insufficiency fractures and did not resemble those seen in NAT.

Paterson: Rickets

- 4 cases; 3 infants, 1 almost 3 year old.
- Rickets is presumably clinically apparent on radiographs of all 4 per table.
- No information regarding abuse.
- Not enough data.
Feldman & Done: Rickets

- Case 1 and 2 did not have Vit D levels reported.
- Case 3 presented with hypocalcemic seizures.
- Rib ends are cropped in case 1.
- Case 2 had dense metaphyses not c/w rickets.
- Case 3—figure shows CML.
- Case 4—had a skull fx, unusual for rickets (in a 9 week old).
- Some had Vit D deficiency, questionable metabolic bone dz, some were probably also abused...

Keller & Barnes: Rickets

- Congenital rickets is “inevitable” due to maternal deficiencies.
- 4 cases/“reports.”
- All were cases they reviewed as defense witnesses.
- Personal profit gained by promoting the existence of congenital rickets.
- ¼ of the court findings disagreed with these authors regarding the cause of the fractures.

http://medicalmisdiagnosisresearch.wordpress.com/2010/12/22/father-found-not-guilty-of-sbs-returns-to-his-family/

REASONABLE DOUBT?
CALLING DR. PATERSON TO THE STAND...


MULTIPLE FRACTURES: TBBD

- Temporary Brittle Bone Disease (TBBD) is not a diagnosis.
- There is no scientific evidence that it exists.


SYMPOSIUM: NONACCIDENTAL TRAUMA IN CHILDREN

Unexplained Fractures: Child Abuse or Bone Disease A Systematic Review

Nirav K. Pandya MD, Keith Baldwin MD, MPH, MSPT, MD-Harish S. Hosalkar MD, MBMS (Ortho), FCPS (Ortho), DNB (Ortho)
There was no association between vitamin D levels and any of the following outcomes: child abuse diagnosis (P = .32), multiple fractures (P = .24), rib fractures (P = .16), or metaphyseal fractures (P = .49).

Pediatrics. 2011 Apr 11. [Epub ahead of print]

Vitamin D Status in Abused and Nonabused Children Younger Than 2 Years Old With Fractures.

Schilling S, Wood JN, Levine MA, Langton D, Christian CW

"There was no association between vitamin D levels and any of the following outcomes: child abuse diagnosis (P = .32), multiple fractures (P = .24), rib fractures (P = .16), or metaphyseal fractures (P = .49)."

DELAYED IDENTIFICATION OF FRACTURES

- Approximately 20% of abusive fractures were missed at initial physician visits.
- In all of these cases, the signs/symptoms of the fracture were observed, but the possibility of abuse was not raised.
- Boys, children who present to a non-pediatric ED or a primary care setting, and/or those with an extremity fracture appeared to be at the greatest risk of missed abuse diagnosis.
- A detailed review of the mechanism of trauma and screening for risk factors for abuse should occur with the evaluation of any young child with a fracture.


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Fractures are only one type of injury seen in physical abuse. A complete evaluation in suspected physical abuse includes obtaining a complete history, physical, lab work, reporting and child abuse pediatrician consultation when needed.

http://champprogram.com/resources.shtml

**Hemo
globin (10-18) g/dl
Mean cell volume (80-120) fl
Platelet count (150-400) x 10^6
Partial thromboplastin time (24.4-34.8) sec
Prothrombin time (12.5-14.8) sec

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FOLLOW-UP HISTORY

- Mother had suffered a broken nose due to DV.
- Baby’s father told the grandparents that the baby fell off the couch on the day seen in the ED and the grandparents note that the discharge papers were wrong about the chief complaint.
- Father incarcerated (felony, reckless assault of a child) after confession to the police.

SUMMARY

- This child suffered from physical abuse.
- Facial trauma, head trauma and multiple fractures (independently) should trigger a medical and social evaluation and investigation for child abuse.
- Vitamin D deficiency without clinical rickets has not been shown to be a cause of multiple fractures and is unlikely to be related to findings that are more characteristic of child abuse injuries.