The Evaluation of Sexual Abuse in Children

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CLINICAL REPORT

Guidance for the Clinician in Rendering Pediatric Care

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The Evaluation of Sexual Abuse in Children

ABSTRACT. This clinical report serves to update the statement titled "Guidelines for the Evaluation of Sexual Abuse of Children," which was first published in 1991 and revised in 1999. The medical assessment of suspected sexual abuse is outlined with respect to obtaining a history, physical examination, and appropriate laboratory data. The role of the physician may include determining the need to report sexual abuse; assessment of the physical, emotional, and behavioral consequences of sexual abuse; and coordination with other professionals to provide comprehensive treatment and follow-up of victims. ***Pediatrics*** **2005;116:506–512;** ***child sexual abuse, sexually transmitted diseases, medical assessment.***

ABBREVIATIONS. AAP, American Academy of Pediatrics; STDs, sexually transmitted disease.

INTRODUCTION

Few areas of pediatrics have expanded so rapidly in clinical importance in recent years as that of sexual abuse of children. What Kempe called a "hidden pediatric problem"[1] in 1977 is certainly less hidden at present. In 2002, more than 88 000 children were confirmed victims of sexual abuse in the United States.[2] Studies have suggested that each year approximately 1% of children experience some form of sexual abuse, resulting in the sexual victimization of 12% to 25% of girls and 8% to 10% of boys by 18 years of age.[3] Children may be sexually abused by family members or nonfamily members and are more frequently abused by males. Boys are reportedly victimized less often than girls but may not be as likely to disclose the abuse. Adolescents are perpetrators in at least 20% of reported cases; women may be perpetrators, but only a small minority of sexual abuse allegations involve women.

Concurrent with the expansion of knowledge, education about child abuse became a mandated component of US pediatric residencies in 1997.[4] Pediatricians will almost certainly encounter sexually abused children in their practices and may be asked by parents and other professionals for consultation. Knowledge of normal and abnormal sexual behaviors, physical signs of sexual abuse, appropriate diagnostic tests for sexually transmitted infections, and medical conditions confused with sexual abuse is useful in the evaluation of such children. All child health professionals should routinely identify those at high risk for or with a history of abuse. Because the evaluation of suspected victims of child sexual abuse often involves careful questioning, evidence-collection procedures, or specialized examination techniques and equipment,[5] many pediatricians do not feel prepared to conduct such comprehensive medical assessments. In such circumstances, pediatricians may refer children to other physicians or health care professionals with expertise in the evaluation and treatment of sexually abused children. Because the scope of practice of some nonphysician examiners is limited to assessment, documentation, and collection of forensic evidence,[6] close coordination with a knowledgeable physician or pediatric nurse practitioner is necessary to provide complete assessment and treatment of physical, behavioral, and emotional consequences of abuse. In other circumstances, the community pediatrician may be asked to evaluate a child for sexual abuse to determine if a report and further investigation are warranted. In some circumstances, pediatricians may conduct comprehensive assessments of suspected victims of child sexual abuse when no other resources are available in their community.

Because pediatricians have trusted relationships with patients and families, they may provide essential support and guidance from the time that abuse is detected and subsequently as the child and family recover from the physical and emotional consequences of abuse. Because of this trusted relationship, the pediatrician may also gain information from the child or family that is valuable to the investigation, evaluation, and treatment of the victim. However, a close relationship between the pediatrician and the family may pose potential tension, prompting the pediatrician to refer the child to a specialist to avoid conflict with the family. Furthermore, although pediatricians must care for sexually abused children in their practice, many report inadequate training in the recognition of red flags for sexual abuse and a lack of a consistent approach to evaluating suspected abuse.[7] Consultation with a pediatric specialist who has extensive training and professional experience in the comprehensive assessment of victims of sexual abuse may be necessary. These guidelines are intended for use by all health professionals caring for children. Additional guide-

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.

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lines are published by the American Academy of Pediatrics (AAP) for the evaluation of sexual assault of the adolescent.[8]

DEFINITION

Sexual abuse occurs when a child is engaged in sexual activities that he or she cannot comprehend, for which he or she is developmentally unprepared and cannot give consent, and/or that violate the law or social taboos of society.[1] The sexual activities may include all forms of oral-genital, genital, or anal contact by or to the child or abuse that does not involve contact, such as exhibitionism, voyeurism, or using the child in the production of pornography.[1] As many as 19% of adolescents who are regular Internet users have been solicited by strangers for sex through the Internet; built-in filters and monitoring are less effective than parent-child communication in preventing online predation.[9] Sexual abuse includes a spectrum of activities ranging from rape to physically less intrusive sexual abuse.

Sexual abuse can be differentiated from "sexual play" by determining whether there is a developmental asymmetry among the participants and by assessing the coercive nature of the behavior.[10] Thus, when young children at the same developmental stage are looking at or touching each other's genitalia because of mutual interest, without coercion or intrusion of the body, this is considered normal (ie, nonabusive) behavior. However, a 6-year-old who tries to coerce a 3-year-old to engage in anal intercourse is displaying abnormal behavior, and appropriate referrals should be made to assess the origin of such behavior and to establish appropriate safety parameters for all children involved. Among nonabused children 2 to 12 years of age, fewer than 1.5% exhibit the following behaviors: putting the mouth on genitals, asking to engage in sex acts, imitating intercourse, inserting objects into the vagina or anus, and touching animal genitals.[11] Children or adolescents who exhibit inappropriate or excessive sexual behavior may be reacting to their own victimization or may live in environments with stressors, boundary problems, or family sexuality or nudity.[12] Some sexually abused children will display a great number of sexual behaviors and a greater intensity of these behaviors.[12] However, there is a significant proportion of sexually abused children who do not display increased sexual behavior. Research has shown that there are 2 responses to sexual abuse: one that reflects inhibition and the other that reflects excitation, and it is in the latter group that more sexual behavior is observed.[13]

PRESENTATION

Sexually abused children are seen by pediatricians in a variety of circumstances such as: (1) the child or adolescent is taken to the pediatrician because he or she has made a statement of abuse or abuse has been witnessed; (2) the child is brought to the pediatrician by social service or law enforcement professionals for a nonacute medical evaluation for possible sexual abuse as part of an investigation; (3) the child is brought to an emergency department after a suspected episode of acute sexual abuse for a medical evaluation, evidence collection, and crisis management; (4) the child is brought to the pediatrician or emergency department because a caregiver or other individual suspects abuse because of behavioral or physical symptoms; or (5) the child is brought to the pediatrician for a routine physical examination, and during the course of the examination, behavioral or physical signs of sexual abuse are detected.

The diagnosis of sexual abuse and the protection of the child from additional harm depend in part on the pediatrician's willingness to consider abuse as a possibility. Sexually abused children who have not disclosed abuse may present to medical settings with a variety of symptoms and signs. Because children who are sexually abused are generally coerced into secrecy, the clinician may need a high level of suspicion and may need to carefully and appropriately question the child to detect sexual abuse in these situations. The presenting symptoms may be so general or nonspecific (eg, sleep disturbances, abdominal pain, enuresis, encopresis, or phobias) that caution must be exercised when the pediatrician considers sexual abuse, because the symptoms may indicate physical or emotional abuse or other stressors unrelated to sexual abuse. More specific signs and symptoms of sexual abuse are discussed under "Diagnostic Considerations." Most cases of child sexual abuse are first detected when a child discloses that he or she has been abused. Children presenting with nonspecific symptoms and signs should be questioned carefully and in a nonleading manner about any stressors, including abuse, in their life. Pediatricians who suspect that sexual abuse has occurred are urged to inform the parents of their concerns in a calm, nonaccusatory manner. The individual accompanying the child may have no knowledge of or involvement in the sexual abuse of the child. A complete history, including behavioral symptoms and associated signs of sexual abuse, should be sought. The primary responsibility of the pediatrician is the protection of the child; if there is concern that the parent with the child is abusive or nonsupportive, the pediatrician may delay in informing the parent(s) while a report is made and an expedited investigation by law enforcement and/or child protective services agencies can be conducted. Whenever there is a lack of support or belief in the child, this information should be provided promptly to child protective services.

TAKING A HISTORY/INTERVIEWING THE CHILD

The pediatrician should try to obtain an appropriate history in all cases before performing a medical examination. Although investigative interviews should be conducted by social services and/or law enforcement agencies, this does not preclude physicians asking relevant questions to obtain a detailed pediatric history and a review of systems. Medical history, past incidents of abuse or suspicious injuries, and menstrual history should be documented. When children are brought for evaluation by protective personnel, little or no history may be available other than that provided by the child. The medical history

should include information helpful in determining what tests should be done and when, how to interpret medical findings when present, and what medical and mental health services should be provided to the child and family.

The courts have allowed physicians to testify regarding specific details of a child's statements obtained in the course of taking a medical history to provide diagnosis and treatment, although exceptions may preclude such testimony in some cases.[14] Occasionally, children spontaneously describe their abuse and indicate who abused them. When asking young children about abuse, line drawings,[15] dolls,[16] or other aids[17] are generally used only by professionals trained in interviewing young children. The American Academy of Child and Adolescent Psychiatry and American Professional Society on the Abuse of Children have published guidelines for interviewing sexually abused children.[18,19] It is desirable for those conducting the interview to avoid leading and suggestive questions or showing strong emotions such as shock or disbelief and to maintain a "tell-me-more" or "and-then-what-happened" approach. When possible, the parent should not be present during the interview so that influences and distractions are kept to a minimum. Written notes in the medical record or audiotape or videotape should be used to document the questions asked and the child's responses as well as their demeanor and emotional responses to questioning. When audiotaping or videotaping is used, protocols should be coordinated with the district attorney's office in accordance with state guidelines. Most expert interviewers do not interview children younger than 3 years.

PHYSICAL EXAMINATION

The physical examination of sexually abused children should not result in additional physical or emotional trauma. The examination should be explained to the child before it is performed. It is advisable to have a supportive adult not suspected of involvement in the abuse[20] present during the examination unless the child prefers not to have such a person present. Children may be anxious about giving a history, being examined, or having procedures performed. Time must be allotted to relieve the child's anxiety.

When the alleged sexual abuse has occurred within 72 hours or there is an acute injury, the examination should be performed immediately. In this situation, forensic evidence collection may be appropriate and may include body swabs, hair and saliva sampling, collection of clothing or linens, and blood samples. Body swabs collected in prepubertal children more than 24 hours after a sexual assault are unlikely to yield forensic evidence, and nearly two thirds of the forensic evidence may be recovered from clothing and linens.[21] When more than 72 hours have passed and no acute injuries are present, an emergency examination usually is not necessary. As long as the child is in a safe and protective environment, an evaluation can be scheduled at the earliest convenient time for the child, physician, and investigative team. The child should have a thorough pediatric examination performed by a health care provider with appropriate training and experience who is licensed to make medical diagnoses and recommend treatment. This examination should include a careful assessment for signs of physical abuse, neglect, and self-injurious behaviors. Injuries, including bruises incurred on the arms or legs during self-defense, should be documented in victims of acute sexual assault. Sexual maturity should also be assessed. In the rare instance in which the child is unable to cooperate and the examination must be performed because of the likelihood of trauma, infection, and/or the need to collect forensic samples, an examination under sedation with careful monitoring should be considered. Signs of trauma should preferably be documented by photographs; if such equipment is unavailable, detailed diagrams can be used to illustrate the findings. Specific attention should be given to the areas involved in sexual activity: the mouth, breasts, genitals, perineal region, buttocks, and anus. In female children, the examination should include inspection of the medial aspects of the thighs, labia majora and minora, clitoris, urethra, periurethral tissue, hymen, hymenal opening, fossa navicularis, posterior fourchette, perineum, and perianal tissues. The thighs, penis, scrotum, perineum, and perianal tissues in males should be assessed for bruises, scars, bite marks, and discharge. Any abnormalities should be noted and interpreted appropriately with regard to the specificity of the finding to trauma (eg, nonspecific, suggestive, or indicative of trauma). If the interpretation of an abnormal finding is problematic, consultation with an expert physician is advisable.

Various examination techniques and positions for visualizing genital and anal structures in children and adolescents have been described.[5] Such techniques are often necessary to determine the reliability of an examination finding; for example, different techniques may be used to ensure that an apparent defect or cleft in the posterior hymen is not a normal hymenal fold or congenital variation. In addition, instruments that magnify and illuminate the genital and rectal areas should be used.[22,23] Speculum or digital examinations should not be performed on the prepubertal child unless under anesthesia (eg, for suspected foreign body), and digital examinations of the rectum are not necessary. Because many factors can influence the size of the hymenal orifice, measurements of the orifice alone are not helpful in assessing the likelihood of abuse.[24]

LABORATORY DATA

Depending on the history of abuse, the examiner may decide to conduct tests for sexually transmitted diseases (STDs). Approximately 5% of sexually abused children acquire an STD from their victimization.[25] The following factors should be considered in deciding which STDs to test for, when to test, and which anatomic sites to test: age of the child, type(s) of sexual contact, time lapse from last sexual contact, signs or symptoms suggestive of an STD, family member or sibling with an STD, abuser with risk factors for an STD, request/concerns of child or fam-

ily, prevalence of STDs in the community, presence of other examination findings, and patient/parent request for testing.[25] Although universal screening of postpubertal patients is recommended,[25] more selective criteria are often used for testing prepubertal patients. For example, the yield of positive gonococcal cultures is low in asymptomatic prepubertal children, especially when the history indicates fondling only.[26] Vaginal, rather than cervical, samples are adequate for STD testing in prepubertal children. Considering the prolonged incubation period for human papillomavirus infections, a follow-up examination several weeks or months after the initial examination may be indicated; in addition, the family and patient should be informed about the potential for delayed presentation of lesions. Testing before any prophylactic treatment is preferable to prophylaxis without testing; the identification of an STD in a child may have legal significance as well as implications for treatment, especially if there are other sexual contacts of the child or perpetrator. The implications of various STDs that may be diagnosed in children are summarized in Table 1; guidelines are also provided by the Centers for Disease Control and Prevention[27] and the AAP.[25,28] The most specific and sensitive tests should be used when evaluating children for STDs. Cultures are considered the "gold standard" for diagnosing *Chlamydia trachomatis* (cell culture) and *Neisseria gonorrhoeae* (bacterial culture). New tests, such as nucleic acid–amplification tests, may be more sensitive in detecting vaginal *C trachomatis*, but data regarding use in prepubertal children are limited. Because the prevalence of STDs in children is low, the positive predictive value of these tests is lower than that of adults, so confirmatory testing with an alternative test may be important, especially if such results will be presented in legal settings. When child sexual abuse is suspected and STD testing is indicated, vaginal/urethral samples and/or rectal swabs for isolation of *C trachomatis* and *N gonorrhoeae* are recommended. In addition, vaginal swabs for isolation of *Trichomonas vaginalis* may be obtained. Testing for other STDs, including human immunodeficiency virus (HIV), hepatitis B, hepatitis C, and syphilis, is based on the presence of symptoms and signs, patient/family wishes, detection of another STD, and physician discretion. Venereal warts, caused by human papillomavirus infection, are clinically diagnosed without testing. Any genital or anal lesions suspicious for herpes should be confirmed with a culture, distinguishing between herpes simplex virus types 1 and 2. Guidelines for treatment are published by the Centers for Disease Control and Prevention.[27]

If a child has reached menarche, pregnancy testing should be considered. A negative pregnancy status should be confirmed before administering any medication, including emergency contraception ("morning after" pills). Guidelines for emergency contraception have been published[29,30]; the AAP is in the process of developing its own guidelines.

DIAGNOSTIC CONSIDERATIONS

The diagnosis of child sexual abuse often can be made on the basis of a child's history. Sexual abuse is rarely diagnosed on the basis of only physical examination or laboratory findings. Physical findings are often absent even when the perpetrator admits to penetration of the child's genitalia.[31–33] Many types of abuse leave no physical evidence, and mucosal injuries often heal rapidly and completely.[34–38] In a recent study of pregnant adolescents, only 2 of 36 had evidence of penetration.[39] Occasionally, a child presents with clear evidence of anogenital trauma without an adequate history. Abused children may deny abuse. Findings that are concerning include: (1) abrasions or bruising of the genitalia; (2) an acute or healed tear in the posterior aspect of the hymen that extends to or nearly to the base of the hymen; (3) a markedly decreased amount of hymenal tissue or absent hymenal tissue in the posterior aspect; (4) injury to or scarring of the posterior fourchette, fossa navicularis, or hymen; and (5) anal bruising or lacerations.[31–36] The interpretation of physical findings continues to evolve as evidence-based research becomes available.[40] The physician, the multidisciplinary team evaluating the child, and the courts must establish a level of certainty about whether a child has been sexually abused. Table 2 provides suggested guidelines for making the decision to report sexual abuse of children based on currently available information. For example, the presence of semen, sperm, or acid phosphatase; a positive culture for *N gonorrhoeae* or *C trachomatis*; or a positive

TABLE 1. Implications of Commonly Encountered STDs for the Diagnosis and Reporting of Sexual Abuse of Infants and Prepubertal Children

STD Confirmed	Sexual Abuse	Suggested Action
Gonorrhea*	Diagnostic†	Report‡
Syphilis*	Diagnostic	Report
HIV infection§	Diagnostic	Report
C trachomatis infection*	Diagnostic†	Report
T vaginalis infection	Highly suspicious	Report
C acuminata infection* (anogenital warts)	Suspicious	Report
Herpes simplex (genital location)	Suspicious	Report‖
Bacterial vaginosis	Inconclusive	Medical follow-up

* If not perinatally acquired and rare nonsexual vertical transmission is excluded.
† Although the culture technique is the "gold standard," current studies are investigating the use of nucleic acid–amplification tests as an alternative diagnostic method in children.
‡ To the agency mandated in the community to receive reports of suspected sexual abuse.
§ If not acquired perinatally or by transfusion.
‖ Unless there is a clear history of autoinoculation.

TABLE 2. Guidelines for Making the Decision to Report Sexual Abuse of Children

Data Available				Response	
History	Behavioral Symptoms	Physical Examination	Diagnostic Tests	Level of Concern About Sexual Abuse	Report Decision
Clear statement	Present or absent	Normal or abnormal	Positive or negative	High	Report
None or vague	Present or absent	Normal or nonspecific	Positive test for *C trachomatis*, gonorrhea, *T vaginalis*, HIV, syphilis, or herpes*	High	Report
None or vague	Present or absent	Concerning or diagnostic findings	Negative or positive	High†	Report
Vague, or history by parent only	Present or absent	Normal or nonspecific	Negative	Indeterminate	Refer when possible
None	Present	Normal or nonspecific	Negative	Intermediate	Possible report,‡ refer, or follow

* If nonsexual transmission is unlikely or excluded.
† Confirmed with various examination techniques and/or peer review with expert consultant.
‡ If behaviors are rare/unusual in normal children.

serologic test for syphilis or HIV infection make the diagnosis of sexual abuse a near medical certainty, even in the absence of a positive history, if perinatal transmission has been excluded for the STDs. The differential diagnosis of genital trauma also includes accidental injury and physical abuse. This differentiation may be difficult and may require a careful history and multidisciplinary approach. Because many normal anatomic variations, congenital malformations and infections, or other medical conditions may be confused with abuse, familiarity with these other causes is important.[41,42]

Physicians should be aware that child sexual abuse often occurs in the context of other family problems, including physical abuse, emotional maltreatment, substance abuse, and family violence. If these problems are suspected, referral for a more comprehensive evaluation is imperative and may involve other professionals with expertise needed for evaluation and treatment. In difficult cases, pediatricians may find consultation with a regional child abuse specialist or assessment center helpful.

After the examination, the physician should provide appropriate feedback, follow-up care, and reassurance to the child and family.

TREATMENT

All children who have been sexually abused should be evaluated by a pediatrician and a mental health professional to assess the need for treatment and to assess the level of family support. Unfortunately, mental health treatment services for sexually abused children are not universally available. The need for therapy varies from victim to victim regardless of abuse chronicity or characteristics. An assessment should include specific questions concerning suicidal or self-injurious thoughts and behaviors. Poor prognostic signs include more intrusive forms of abuse, more violent assaults, longer periods of sexual molestation, and closer relationship of the perpetrator to the victim. The parents of the victim may also need treatment and support to cope with the emotional trauma of their child's abuse; parents who are survivors of child abuse should be identified to ensure appropriate therapy and to optimize their ability to assist their own child in the healing process. Treatment may include follow-up examinations to assess healing of injuries and additional assessment for STDs, such as *Condylomata acuminata* infection or herpes, that may not be detected in the acute time frame of the initial examination. The pediatrician may also provide follow-up care to ensure that the child and supportive family members are recovering emotionally from the abuse.

LEGAL ISSUES

The medical evaluation is first and foremost just that: an examination by a medical professional with the primary aim of diagnosing and determining treatment for a patient's complaint. When the complaint involves the possible commission of a crime, however, the physician must recognize legal concerns. The legal issues confronting pediatricians in evaluating sexually abused children include manda-

tory reporting of suspected abuse with penalties for failure to report; involvement in the civil, juvenile, or family court systems; involvement in divorce or custody proceedings; and involvement in criminal prosecution of defendants in criminal court. In addition, there are medical liability risks for pediatricians who fail to diagnose abuse or who misdiagnose other conditions as abuse. All pediatricians in the United States are required under the laws of each state to report suspected as well as known cases of child abuse. In many states, the suspicion of child sexual abuse as a possible diagnosis requires a report to both the appropriate law enforcement and child protective services agencies. Among adolescents, sexual activity and sexual abuse are not synonymous, and it should not be assumed that all adolescents who are sexually active are, by definition, being abused. Many adolescents have consensual, age-appropriate sexual experiences, and it is critical that adolescents who are sexually active receive appropriate confidential health care and counseling. Federal and state laws should support providing confidential health care and should affirm the authority of physicians and other health care professionals to exercise appropriate clinical judgment in reporting cases of sexual activity.[43] All physicians need to know their state law requirements and where and when to file a written report; an update on child abuse reporting statutes can be accessed at http://nccanch.acf.hhs.gov/general/legal/statutes/manda.cfm. These guidelines do not suggest that a pediatrician who evaluates a child with an isolated behavioral finding (nightmares, enuresis, phobias, etc) or an isolated physical finding (erythema or an abrasion of the labia or traumatic separation of labial adhesions) is obligated to report these cases as suspicious. If additional historical, physical, or laboratory findings suggestive of sexual abuse are present, the physician may have an increased level of suspicion and should report the case. In both criminal and civil proceedings, physicians must testify to their findings "to a reasonable degree of medical certainty."[44] Pediatricians are encouraged to discuss cases with their local or regional child abuse consultants and their local child protective services agency. In this way, families may be spared unnecessary investigations, agencies are less likely to be overburdened, and physicians may be protected from potential prosecution for failure to report. Statutes in each state immunize reporters from civil or criminal liability as long as the report was not made either without basis or with deliberate bad intentions.[45] On the other hand, although no known physicians have been prosecuted successfully for failure to report, there have been successful malpractice actions against physicians who failed to diagnose or report child abuse appropriately.[45]

Because of the likelihood of legal action, detailed records, drawings, and/or photographs should be maintained soon after the evaluation and kept in a secure location. Protected health information for a minor who is believed to be the victim of abuse may be disclosed to social services or protective agencies; the Health Insurance Portability and Accountability Act (HIPAA; Pub L No. 104–191 [1996]) does not preempt state laws that provide for reporting or investigating child abuse. Physicians required to testify in court are better prepared and may feel more comfortable if their records are complete and accurate. Physicians may testify in civil cases concerning temporary or permanent custody of the child by a parent or the state or in criminal cases in which a suspected abuser's guilt or innocence is determined. In general, the ability to protect a child may often depend on the quality and detail of the physician's records.[37]

A number of cases of alleged sexual abuse involve parents who are in the process of separation or divorce and who allege that their child is being sexually abused by the other parent during custodial visits. Although these cases are generally more difficult and time consuming for the pediatrician, the child protective services system, and law enforcement agencies, they should not be dismissed simply because a custody dispute exists. Whenever a careful and comprehensive assessment of the child's physical and behavioral symptoms yields a suspicion of abuse or the child discloses abuse to the physician, a report to protective services should be made. If symptoms or statements are primarily reported by the parent but not supported during an assessment of the child, the physician may wish to refer the family to a mental health or sexual abuse expert. A juvenile court proceeding may ensue to determine if the child needs protection. The American Bar Association indicates that most divorces do not involve custody disputes, and relatively few custody disputes involve allegations of sexual abuse.[44]

CONCLUSIONS

The evaluation of sexually abused children is increasingly a part of general pediatric practice. Pediatricians are part of a multidisciplinary approach to prevent, investigate, and treat the problem and need to be competent in the basic skills of history taking, physical examination, selection of laboratory tests, and differential diagnosis. An expanding clinical consultation network is available to assist the primary care physician with the assessment of child abuse cases.[46]

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