
The doctors' role in cases of suspected child abuse

OPINIONS

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Violent shaking of infants may lead to a triad of serious injuries to the head and eyes. The question of whether the triad can be used to establish child abuse has been raised. But is the matter that simple?

The term 'shaken baby syndrome' (SBS), which was introduced almost 50 years ago [\(1\)](#), denotes a serious pattern of symptoms and injuries in children under three years of age that is likely caused by inflicted trauma [\(2\)](#). Typical symptoms are lethargy, poor appetite, vomiting or retching, epileptic seizures and reduced consciousness. Most of these children have subdural haematoma, possibly combined with subarachnoid bleeding. Other findings include bruising, skin lesions and retinal haemorrhages in one or both eyes. Fractures to the skull, ribs and long bones are common. In the most serious cases, there is evidence of brain injury, accompanied by a high risk of neurological sequelae or

death. The child's caregiver rarely offers an adequate explanation for the child's injuries, and the story presented often contains inconsistencies. Incongruence between the injury severity and the history presented by the caregiver, in addition to a distinctive pattern of injuries, should lead healthcare personnel to suspect that the child has been subject to physical abuse.

Critique of evidence base and practice

In a 'Perspectives' article in the Journal of the Norwegian Medical Association, Knut Wester expresses his concern about the uncertainty involved in diagnosing 'shaken baby' cases (3). He claims that a number of people may have been convicted of having shaken a child based on insufficient medical evidence. He is currently working on a research project in which he will review previous court convictions to see whether this could be the case. Wester bases his assertions partly on a Swedish literature review from 2016 that appears to conclude that there is insufficient scientific evidence for shaken baby syndrome (4).

Wester's concerns must be taken seriously. It is our opinion, however, that the medical evidence for the diagnosis of physical abuse of children in general, and abusive head injury in particular, is far stronger than he proposes. In our view, both Wester and the authors of the Swedish literature review have used definitions that deviate from the real issue in the diagnostic workup.

Wester defines the diagnosis of the shaken baby as a triad of medical findings: subdural haematoma, extensive retinal haemorrhages and encephalopathy. This is a drastic oversimplification of the clinical presentation, and it is completely misleading when used as the sole grounds for the diagnosis. A finding of the so-called triad is not in itself sufficient proof of child abuse. It is true that in a forensic setting the triad has been used as an indicator that violent shaking may have been the mechanism of injury (5, 6). This assumes, however, that other findings point in the same direction and that an extensive workup has been conducted that critically assesses other potential mechanisms of injury and differential diagnoses. The three triad variables have distinctive features that may indicate abuse, but they cannot be used as binary yes-no variables.

Firstly, a *subdural haematoma* has a distribution, form, size and a radiological/pathological pattern that varies from case to case depending on the injury mechanism, pathophysiology, coexisting pathology and age. In a typical case of traumatic shaking, the haematomas are multifocal/bilateral and occur over the hemispheres, posteriorly and/or along the falx cerebri (7). There are often signs of injury to bridging veins at the midline (tadpole signs). At autopsy, injury to bridging veins can also be noted by careful dissection (8, 9).

Secondly, in typical cases of traumatic shaking, *retinal haemorrhages* have a characteristic appearance with numerous haemorrhages in multiple layers of the retina, located both centrally and peripherally in all four quadrants, but with a normal optic nerve papilla (10). This is substantially different from the retinal haemorrhages described in relation to an acute increase in intracranial

pressure in which the haemorrhages are typically found only centrally and papilloedema is clearly present [\(11\)](#). In a prospective, population-based study with 45 cases of known/admitted traumatic shaking, there was a specificity of 97 % for traumatic shaking in cases of major preretinal haemorrhages together with other extensive retinal haemorrhages with or without retinoschisis (formation of folds around the macula) [\(12\)](#).

Thirdly, the term *encephalopathy* encompasses any conceivable type of brain injury. Very few shaken children have structural signs of brain injury [\(2\)](#). When disclosed, such signs often entail rapid development of cytotoxic oedema and diffuse brain tissue damage that may indicate a hypoxic-ischemic mechanism related to trauma. Such brain injuries may be asymmetrical, but are most often bilateral. In some cases an MRI may reveal a resemblance to hypoxic-ischemic injuries subsequent to circulatory failure resulting from a specific incident or illness [\(7\)](#). The child's medical history must be carefully reviewed to rule out such incidents. Less frequently, traumatic shaking can lead to more widespread/extensive brain injury of the type known as 'diffuse axonal injury' associated with high-energy trauma [\(6, 7\)](#).

When focus is placed solely on the triad, this implies a choice to disregard the other accompanying findings such as skeletal fractures and bruises as well as signs of caregiver neglect. [\(2\)](#). The Swedish literature review from 2016 concluded that there was insufficient scientific evidence to claim that children with the triad of findings had been violently shaken [\(4\)](#). However, the committee that conducted the study ignored all other clinical aspects and findings that are given weight when making a diagnosis [\(13\)](#). Since its publication, the Swedish report has been criticised for its methodological weaknesses and flawed reasoning [\(14, 15\)](#), and the Royal College of Paediatrics and Child Health in the UK has urged the authors to withdraw the publication or allow it to be subjected to international scrutiny [\(14\)](#).

Shaking and other abuse

The term 'shaken baby' suggests that the children have been violently shaken, presumably held around the upper torso with both hands and shaken back and forth multiple times. The mechanism implies that the child's head has been subjected to powerful jerks (acceleration and deceleration forces). Many children, however, also show signs of blunt force trauma to the head/face [\(2, 16\)](#). On this basis, the term 'shaking-impact syndrome' was introduced [\(16\)](#). Later on, the American Academy of Pediatrics proposed the term 'abusive head trauma' (AHT) [\(2\)](#). This term indicates that the injuries are caused by inflicted trauma, but gives latitude for variations in the mechanism of injury. When the typical characteristics of the triad are present, they may point to violent shaking as the mechanism of injury, but there are also other physical injuries that may indicate violent shaking, such as external injuries from harsh gripping and fractured ribs and long bones [\(1, 2, 6, 13, 14\)](#).

In order to be convicted in a criminal case, culpability must be proven beyond a reasonable doubt, and the courts rely on medical forensic experts in such cases. Although it may be obvious in some cases that the child was injured through abuse, it may be difficult for the experts (and the court) to determine *when* and *how* this occurred and how much force was involved. It is notable that even a child who shows no external signs of injury may have been subjected to violent abuse, causing severe injuries to the brain and eyes. Individuals who have confessed report that the shaking which resulted in injury to their children was part of a repetitive pattern of behaviour; the children were shaken as a reaction to prolonged/inconsolable wailing and crying (17). According to these admissions, the intensity and length of time that the children are shaken before they sustain severe injuries varies. Perhaps it is the individual differences in children that determine how much violent jerking, pushing and/or shaking they can 'tolerate'.

Workup, diagnosis and interdisciplinary teamwork

A number of conditions and differential diagnoses must be ruled out in the workup for potential abusive head injury. Birth-related injuries, congenital diseases, haemorrhagic conditions and unrecognised traumas may produce symptoms that resemble those seen in abusive head injury. The clinical workup must therefore be highly specialised and interdisciplinary, involving specialists such as paediatricians, ophthalmologists, radiologists, neurosurgeons and specialists in medical biochemistry. In our view, doubt based on an incomplete understanding of the situation could prevent healthcare personnel from making an important diagnosis. Current legislation requires healthcare personnel to report suspected child abuse to the child welfare services and to consider filing a report with the police as well. Failing to recognise that a child has been a victim of abuse can have major and fatal consequences for the child.

Knut Wester's clinical alternative explanation for violent shaking is the condition 'benign external hydrocephalus' (BEH), also known as macrocrania and 'benign enlargement of subarachnoid spaces' (BESS). This has been included for more than 20 years in the differential diagnostic considerations that medical forensic experts should consider in their assessments. There is evidence that this condition may result in spontaneous subdural leakage of blood components and fluid (18). Thus, it is crucial for the attending doctors and medical forensic experts to know whether this condition is present when an infant is diagnosed with subdural haematoma. In such cases, increased fluid in the subarachnoid space is present alongside the subdural haematoma. The boundary between normal and potentially pathological amounts of subarachnoid fluid, which indicates a diagnosis of benign external hydrocephalus, has been previously documented in a prospective study of 120 healthy neonates who were followed up at eight months with cerebral ultrasound (19). Rarely are there pre-incident images available showing that benign external hydrocephalus was present prior to detection of subdural

bleeding. In such cases, it is important to compile an overview of previous head circumference measurements and neuroradiological assessments of CT/MRI images.

It is clear, however, that benign external hydrocephalus is not associated with bruising or bone fractures, nor can it explain widespread retinal haemorrhages, hypoxic-ischemic brain injury or other serious outcomes (2).

Abusive head injury is not a specific medical diagnosis that can be ascertained through a medical workup alone. The difficult decision for the clinician is whether the medical findings give grounds for notifying the child welfare services and possibly the police. This assessment must be made on the soundest possible basis and by competent healthcare personnel with knowledge about and experience with sick/injured children. It is the prosecuting authorities – *not* the doctors – that decide whether there are grounds for police investigation and possible criminal charges.

Sufficient evidence

It is good to question established medical 'truths', and we welcome all research in this area. However, we are concerned that biased, oversimplified news stories will have major consequences for children's safety and legal protection in the future. In our opinion, the current evidence base is so sound that it enables violent shaking and other rough handling of children to be established through an extensive medical workup by competent experts. It is essential that we work in an interdisciplinary manner with these difficult cases and that we as medical doctors concentrate on our tasks – to prevent illness and injury, reach diagnoses, alleviate suffering and treat patients. Doctors who perform tasks as medical/forensic experts must be cautious, precise and objective so that the courts have the best conditions under which to weigh the evidence.

LITERATURE

1. Caffey J. The whiplash shaken infant syndrome: manual shaking by the extremities with whiplash-induced intracranial and intraocular bleedings, linked with residual permanent brain damage and mental retardation. *Pediatrics* 1974; 54: 396–403. [PubMed]
2. Choudhary AK, Servaes S, Slovis TL et al. Consensus statement on abusive head trauma in infants and young children. *Pediatr Radiol* 2018; 48: 1048–65. [PubMed][CrossRef]
3. Wester K. Har et «filleristet spedbarn» alltid vært filleristet? *Tidsskr Nor Legeforen* 2018; 138. doi: 10.4045/tidsskr.18.0583. [PubMed][CrossRef]
4. Lynøe N, Elinder G, Hallberg B et al. Insufficient evidence for 'shaken baby syndrome' - a systematic review. *Acta Paediatr* 2017; 106: 1021–7. [PubMed][CrossRef]

5. Harding B, Risdon RA, Krous HF. Shaken baby syndrome. *BMJ* 2004; 328: 720–1. [PubMed][CrossRef]
6. National Association of Medical Examiners Ad Hoc Committee on Shaken Baby Syndrome. Position paper on fatal abusive head injuries in infants and young children. *Am J Forensic Med Pathol* 2001; 22: 112–22. [PubMed][CrossRef]
7. Kemp AM, Jaspan T, Griffiths J et al. Neuroimaging: what neuroradiological features distinguish abusive from non-abusive head trauma? A systematic review. *Arch Dis Child* 2011; 96: 1103–12. [PubMed][CrossRef]
8. Matschke J, Voss J, Obi N et al. Nonaccidental head injury is the most common cause of subdural bleeding in infants <1 year of age. *Pediatrics* 2009; 124: 1587–94. [PubMed][CrossRef]
9. Hahnemann ML, Kinner S, Schweiger B et al. Imaging of bridging vein thrombosis in infants with abusive head trauma: the "Tadpole Sign". *Eur Radiol* 2015; 25: 299–305. [PubMed][CrossRef]
10. Binenbaum G, Forbes BJ. The eye in child abuse: key points on retinal hemorrhages and abusive head trauma. *Pediatr Radiol* 2014; 44 (Suppl 4): S571–7. [PubMed][CrossRef]
11. Binenbaum G, Rogers DL, Forbes BJ et al. Patterns of retinal hemorrhage associated with increased intracranial pressure in children. *Pediatrics* 2013; 132: e430–4. [PubMed][CrossRef]
12. Vinchon M, de Foort-Dhellemmes S, Desurmont M et al. Confessed abuse versus witnessed accidents in infants: comparison of clinical, radiological, and ophthalmological data in corroborated cases. *Childs Nerv Syst* 2010; 26: 637–45. [PubMed][CrossRef]
13. Maguire SA, Kemp AM, Lumb RC et al. Estimating the probability of abusive head trauma: a pooled analysis. *Pediatrics* 2011; 128: e550–64. [PubMed]
14. Child Protection Standing Committee, Royal College of Paediatrics and Child Health. Abusive head trauma and the triad: a critique on behalf of RCPCH of 'Traumatic shaking: the role of the triad in medical investigations of suspected traumatic shaking'. *Arch Dis Child* 2018; 103: 606–10. [PubMed][CrossRef]
15. Biló RAC, Banaschak S, Herrmann B et al. Using the table in the Swedish review on shaken baby syndrome will not help courts deliver justice. *Acta Paediatr* 2017; 106: 1043–5. [PubMed][CrossRef]
16. Duhaime AC, Gennarelli TA, Thibault LE et al. The shaken baby syndrome. A clinical, pathological, and biomechanical study. *J Neurosurg* 1987; 66: 409–15. [PubMed][CrossRef]

17. Adamsbaum C, Grabar S, Mejean N et al. Abusive head trauma: judicial admissions highlight violent and repetitive shaking. *Pediatrics* 2010; 126: 546–55. [PubMed][CrossRef]
 18. Vinchon M, Delestret I, DeFoort-Dhellemmes S et al. Subdural hematoma in infants: can it occur spontaneously? Data from a prospective series and critical review of the literature. *Childs Nerv Syst* 2010; 26: 1195–205. [PubMed][CrossRef]
 19. Gravendeel J, Rosendahl K. Cerebral biometry at birth and at 4 and 8 months of age. A prospective study using US. *Pediatr Radiol* 2010; 40: 1651–6. [PubMed][CrossRef]
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