Bruises in Immobile Children

Author: Dr F Howsam (Named doctor), Dr L Perera (Paediatric Consultant), Dr M Flynn (Named GP), Yvette Queffrus (Named HV) & Dr I Green (Paed trainee)
Publication date: June 2022. Version 3
Review date: June 2024

See also: Subconjunctival haemorrhage guideline on Paediatric Microguide

Bruising is the most common injury in children who have been abused. It is also a common injury in non-abused children, the exception to this being pre-mobile infants where accidental bruising is rare (0-1.3%). Bruising in an infant who is not independently mobile should raise suspicion of maltreatment (see RCPCH child protection portal for evidence)

Red flag signs for physical abuse

- Bruising in children who are not independently mobile
- Bruises seen away from bony prominences
- Bruises to the face, abdomen, arms, buttocks, ears, neck, hands
- Multiple bruises in clusters
- Multiple bruises of uniform shape
- Bruises that carry the imprint of implement used or a ligature
- Bruises that are accompanied by petechiae, in absence of underlying bleeding disorder

- A bruise must be interpreted in the context of medical, social, developmental history and explanation given. A small proportion of babies with suspicious marks may have a medical explanation, however bruises in children <6 months old are predominantly non-accidental in aetiology, and therefore early social care involvement is appropriate.

- A parent leaflet is available to provide to parents to explain the need for further assessment and the involvement of social care at the outset. GPs have a pathway which mirrors ours. They should be contacting social care directly when they are unsure.

Not Independently Mobile = not crawling, bottom shuffling, commando crawling, pulling to stand, cruising or walking. **Therefore this guidance automatically applies to all children under 6 months of age or to any immobile child e.g. older children with disabilities.**
The outcome of assessments involving RACH must be fed back to health visitor and GP in writing. When performing a CP a provisional opinion form may be of use.

The baby will need assessment at RACH (see below)

The paediatrician's responsibility is to:

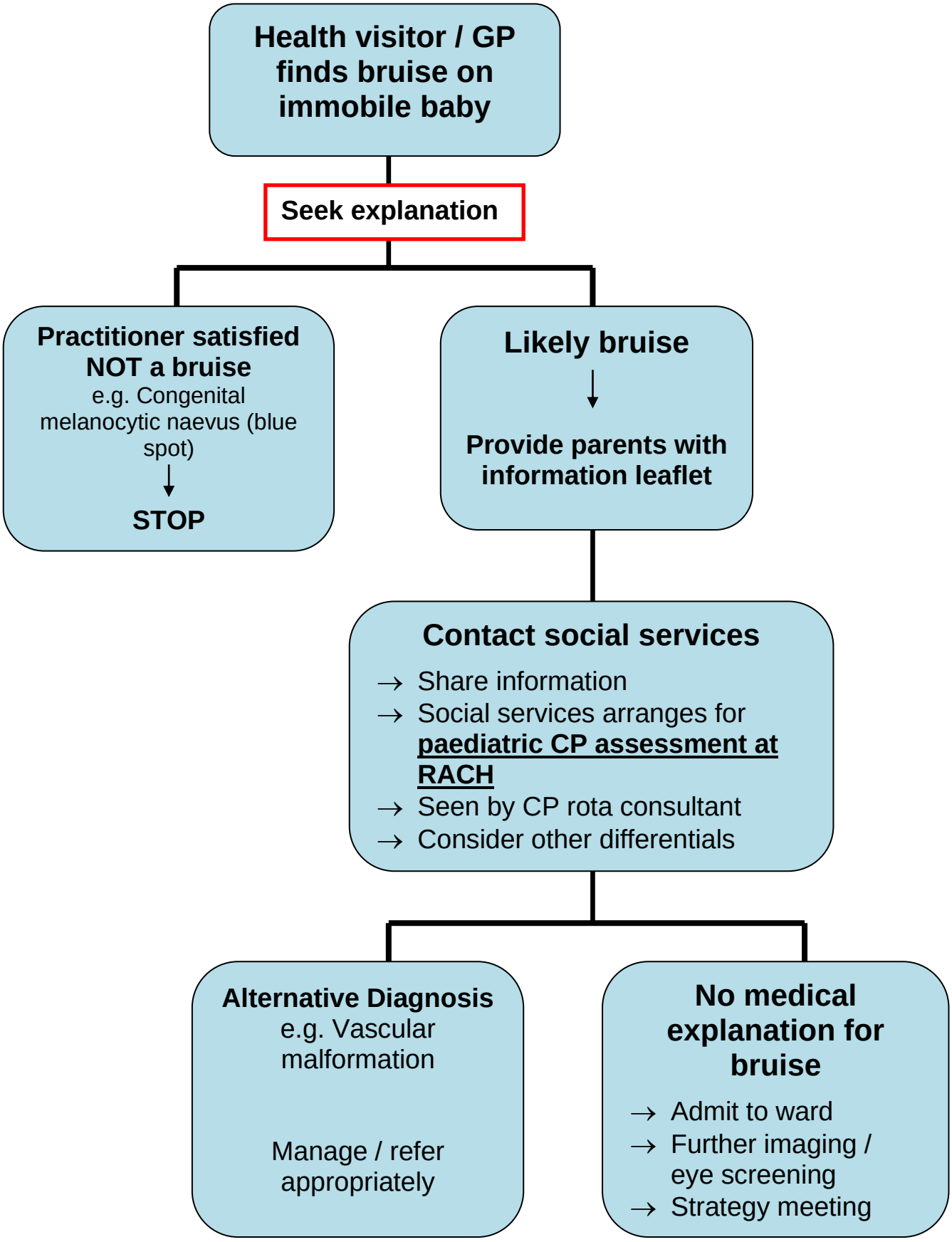
- take detailed history of birth, medical details, family bleeding history
- perform thorough top to toe examination including all skin surfaces, orifice, ano-genital
- perform bloods (see "**baseline tests when NAI is suspected**" guideline on Microguide)
- Consider differential diagnosis and consultant dermatology opinion needed
- Liaise with social care
- decide about admission, strategy meeting and further investigations warranted

Pertinent Differentials for Consultant to consider – BUT *mimics can co-exist with NAI*

- Congenital melanocytic naevus (blue spot), capillary haemangioma – consider USS or review.
- Bleeding Condition/ Neonatal AITP
- Mastocytoma/urticarial vascultis
- AHEI (Acute Heamorrhagic Oedema of Infancy)
- Panniculitis

There are case reports of suction bruises on forearm (BUT should be seen at RACH to be sucking the area spontaneously - may need forensic dental opinion to verify.)

Bruise pathway for immobile children



References

1. Bruising – A systematic review. (September 2010) Welsh Child Protection Systematic Review Group.
2. http://guidance.nice.org.uk/CG89
3. https://www.rcpch.ac.uk/sites/default/files/2020-03/child_protection_evidence-_chapter_bruising_update_final.pdf