Objectives

• Recognition of patients who are victims of medical child abuse

• Understand the process to address the child’s abuse, both clinically and in the context of HIPAA and Child Protective Services agency involvement

• Consider screening your patient population for medical child abuse
Case Presentation

Jose Ruben Rodriguez, MD
Assistant Professor of Pediatric Surgery
The Patient – an 8-Year-Old Boy

• Gastric Dysmotility/Neuropathic colon
  - GJ feeds (poor tolerance) → Central line(s) for TPN
  - Cecostomy → ileostomy
  - Extensive workup (endoscopies/ antroduodenal manometry/ metabolic/ genetic/ neurohormonal testing and contrast studies) negative

• Neurogenic bladder
  - Straight catheterization

• History of abusive head trauma, ADHD, Pervasive Developmental Delay (home school) multiple psychotropics
Symptom Progression

• Concerning weight loss during home stays

• Good weight gain during hospitalizations

• Admitted with 5lb weight loss

• Developed PICC infection (bacillus not Anthraces), treated
Symptom Progression

• Sudden increase ileostomy output once weight gain in house well-established...

Net loss of 18 L + Normal electrolytes
Ongoing good weight gain
Surgical Involvement

• Surgery consultation was obtained

• Previous rectal biopsies were reviewed by TCH pathologist – no evidence of Hirschsprung’s disease

• Distal contrast study was obtained
• The colon is normal in caliber and normal in position

• After a few minutes of intermittent fluoroscopic evaluation, no contrast passed proximally to the ileum consistent with end ileostomy
Implausible History → ?Abuse?

- Child protection team consulted
- Therapeutic separation initiated
- Reduction of medical therapy
  - Oral feeding
  - Spontaneous voiding
  - Active all over inpatient floor/playroom
Surgical Course

• Taken to Operating Room 3 weeks into separation

• Gastrojejunostomy tube removed

• Removal of tunneled central line

• Laparoscopy, mobilization of the right colon, ileostomy closure with ileocolostomy
Follow-up

• Postoperatively, child recovered intestinal function POD 3

• Diet was gradually advanced

• Fully enterally sufficient

• Excellent weight gain (>8 pounds)
Growth Chart Following Separation
Status at Time of Discharge

• Discontinuation of urinary catheterizations
• Normal neuropsychiatric evaluation off medications
• Foster home
Reflections from Surgical Consultant
Medical Child Abuse: When the History Is Misleading

Marcella Donaruma-Kwoh, MD, FAAP
Assistant Professor, Pediatrics
Child Protection Team
Section of Public Health Pediatrics
Baylor College of Medicine
Munchausen’s Syndrome by Proxy?
What Does “Munchausen’s” Mean?

- “Tall tales of comic extravagance”
- “False and ridiculously exaggerated exploits”
- Karl Friedrich Hieronymous
What Raises Concern for a “Munchausen’s” Diagnosis?

Richard Asher (1951)

Sir Roy Meadow (1977)
Components of Munchausen’s By Proxy

Illness in a child that is simulated and/or produced by a parent or someone who is *in loco parentis*
How Do They Fake It?

- Exaggerate
- Fabricate (Lie)
- Simulates (Fake)
- Induce

...Illness in another person
Presentation of the child for medical assessment and care, usually persistently, often resulting in multiple medical procedures
Denial of knowledge by the perpetrator as to the etiology of the child’s illness
Acute symptoms and signs of the child abate when the child is separated from the perpetrator.
Munchausen’s….by Proxy…
...also known as...

PEDIATRIC CONDITION

FALSIFICATION
CHILD ABUSE IN THE MEDICAL SETTING

...also known as...
...or...

CAREGIVER-FABRICATED ILLNESS IN A CHILD
best understood as

MEDICAL CHILD ABUSE
Whatever you call it, be sure to call it MEDICAL CHILD ABUSE
...at Texas Children’s Hospital
...at Texas Children’s Hospital

![Graph showing the number of MCA consults from 2006 to 2016. The y-axis represents the number of consults, ranging from 0 to 25. The x-axis represents the years 2006 to 2016. The graph shows a general increase in the number of consults over the years.]

# MCA consults
...at Texas Children’s Hospital
Who Are the Victims?

• Typically toddlers and infants

• Often a delay between onset of symptoms and diagnosis
  - In 2 large series, 15-22 months was common

• Older children may adopt false signs and symptoms
  - These children may go on to develop Munchausen syndrome or personality disorders themselves
Who Are Their Caretakers?

• Usually mothers

• Common to have medical background

• Uncommon to have employment outside the home (or medical field)

• Mental illness
Who Are the Providers?

...probably us
Who Are the Providers?

• Any type of pediatricians
  - General specialty (FP, Peds, Surgery)
  - Sub-boards
  - Sub-sub boards

• Unspoken medical contract
Case Example

• Full-term baby, product of IVF

• Poor latch-on in hospital

• Frequent visits for difficulty feeding
  - Formula changed x 2
  - OT input sought

• Mother has ongoing concerns about feeding difficulty at 4 months of age
Reflect on Your Coalescing DDX list
Weight-for-age percentiles: Girls, birth to 36 months
What would you recommend as the next best step?

A. Support current plan

B. Recommend a new formula

C. Prescribe medication to treat GERD

D. GI subspecialty referral for poor feeding
Weight-for-age percentiles: Girls, birth to 36 months
Case Example

• 5 mos old – GT placed for poor feeding
Case Example

• …Poor tolerance of GT feeds

• Vomiting persistent – GT converted to G-J – displaced often, feeds stopped/interrupted

• Full TPN indicated → central line
Case Example

• Central line infections (unusual bugs)

• → repeated line placements + more infections
  - Query immune deficiency?

• Anemia

• Electrolyte imbalances occur

• Seizures begin............
MCA: the Challenges

It can be confusing to talk with the perpetrator of PCF/MCA
MCA: the Challenges

MCA can also occur in children who have a true underlying medical condition
MCA: the Challenges

MCA can also occur in children who have a true underlying medical condition

and

Some parents truly are just high-anxiety and/or have a sense of a “vulnerable child”
More Challenges

- Information is complicated to follow chronologically
- Difficult to corroborate
- Simply atypical
And Still More Challenges

- Often diagnoses that are difficult to confirm or disprove are latched onto with great enthusiasm.

- Many of the children who suffer from MCA are described as seriously ill, chronically ill, or having special healthcare needs.
Abusing Caregivers Are Wily

If confronted, caregiver typically removes the child from the

• Practice
• Broader medical community
• Geographical area

...to seek care elsewhere
MCA: the Consequences

Needless (potentially harmful) investigations and treatments
MCA – Outcomes

• Morbidity is 100%

• Up to 75% fatality rate
  - When the children are young (0-6 months)
  - Caregiver induces the symptoms
    • (especially suffocation)
Questions to Ask Yourself

• Are the history, signs, and symptoms of disease credible?

• Is the child receiving unnecessary and harmful or potentially harmful medical care?

• If so, who is instigating the evaluations and treatment?
What Might You See in These Kids?
Caregiver-Fabricated Illness in a Child: A Manifestation of Child Maltreatment

Abstract

TABLE 1 Symptoms and Signs by System Involved

<table>
<thead>
<tr>
<th>System Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergic</td>
</tr>
<tr>
<td>Dermatologic</td>
</tr>
<tr>
<td>Developmental</td>
</tr>
<tr>
<td>Endocrine</td>
</tr>
<tr>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>Hematologic</td>
</tr>
<tr>
<td>Infection</td>
</tr>
<tr>
<td>Metabolic</td>
</tr>
<tr>
<td>Neurologic</td>
</tr>
<tr>
<td>Oncologic</td>
</tr>
<tr>
<td>Ophthalmic</td>
</tr>
<tr>
<td>Orthopedic</td>
</tr>
<tr>
<td>Otic</td>
</tr>
<tr>
<td>Renal</td>
</tr>
<tr>
<td>Respiratory</td>
</tr>
<tr>
<td>Rheumatologic</td>
</tr>
</tbody>
</table>

Data are from refs 2, 3, and 7.
<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/25/2002</td>
<td>Age 6, having breakthrough seizures since discontinuing Tegretol (by maternal report)</td>
</tr>
<tr>
<td>3/25/2002</td>
<td>Valproate level = &lt;0.7 ug/mL</td>
</tr>
<tr>
<td>6/24/2002</td>
<td>Abnormal EEG; spike and sharp waves in L and R temporal regions</td>
</tr>
<tr>
<td>6/24/2002</td>
<td>Mother plans to send him to daycare center across the street where her sister works</td>
</tr>
<tr>
<td>7/3/2002</td>
<td>Mother doesn't finish food w/ VPA sprinkles; d/c VPA, start Zonegran</td>
</tr>
<tr>
<td>7/18/2002</td>
<td>Took off Zonegran. D/t advice of Dr. ___? To ER for seizure where he &quot;passed out&quot;</td>
</tr>
<tr>
<td>7/19/2002</td>
<td>Went to daycare &quot;until he had seizures every day&quot;</td>
</tr>
<tr>
<td>8/1/2002</td>
<td>10 min seizure. She is giving medicine, but in a 4oz bottle; doesn't always finish. &quot;Unclear that mom will follow instructions&quot;</td>
</tr>
<tr>
<td>10/11/2002</td>
<td>Increase Zonegran dose d/t reports of increased sz frequency</td>
</tr>
<tr>
<td>10/15/2003</td>
<td>Undetectable Zonegran level</td>
</tr>
<tr>
<td>1/1/2004</td>
<td>Constipated in ER. UA w/ &gt;20 RBCs, + crystals --?kidney stone. had 4 seizures last week. Lost 4 teeth</td>
</tr>
<tr>
<td>1/6/2004</td>
<td>KUB, CT A/P no stones</td>
</tr>
<tr>
<td>1/21/2004</td>
<td>Had a seizure today. Fell and lost a tooth</td>
</tr>
<tr>
<td>1/24/2004</td>
<td>Urology referral. +phimosis - possibly related to hematuria/abd pain. Rx'd triamcinolone</td>
</tr>
<tr>
<td>2/13/2004</td>
<td>Seizures 2x weekly on Zonegran with &quot;questionable compliance&quot;</td>
</tr>
<tr>
<td>2/13/2004</td>
<td>Mom thinks ___ could return to school after circumcision surgery</td>
</tr>
<tr>
<td>2/13/2004</td>
<td>Zonegran level &lt; 5</td>
</tr>
<tr>
<td>2/19/2004</td>
<td>Mom reports: mixes into a full glass of milk; he doesn't drink. Caller stressed importance of meds, will check levels</td>
</tr>
<tr>
<td>2/26/2004</td>
<td>Zonegran level = 13 ug/mL (nl 10-40)</td>
</tr>
<tr>
<td>5/24/2004</td>
<td>Report of &quot;frequent UTIs&quot;; child has had frequent ER visits; NO + UCxs</td>
</tr>
<tr>
<td>5/24/2004</td>
<td>Still home schooled. Mom states she plans to enroll him in public school in the fall</td>
</tr>
<tr>
<td>7/14/2004</td>
<td>Urology: Hematuria post meatoplasty. No infxn. +Constipation, rx'd Miralax</td>
</tr>
<tr>
<td>12/13/2004</td>
<td>Mother reports child will start school 1/2005</td>
</tr>
<tr>
<td>5/4/2005</td>
<td>Decreased frequency of szs on increased frequency of Zonegran dosing</td>
</tr>
<tr>
<td>5/4/2005</td>
<td>Mother plans on meeting w/members of school board this summer to make arrangements for ___ to start in Fall</td>
</tr>
<tr>
<td>5/4/2005</td>
<td>Zonegran level = 6 ug/mL</td>
</tr>
<tr>
<td>5/19/2005</td>
<td>Going back to Hicks Elementary wanted to know if SW could help w/paperwork</td>
</tr>
<tr>
<td>12/28/2005</td>
<td>&quot;had swallowed his tongue&quot; and she thought he had died - went to TCH ER. Zonegran increased</td>
</tr>
<tr>
<td>1/31/2006</td>
<td>Mom told psych that I had insisted on MRI of brain. MD has not seen pt since July 2005.</td>
</tr>
<tr>
<td>1/31/2006</td>
<td>Mother is inconsistent (particularly re: AH/VH), records not available (MD has retired)</td>
</tr>
<tr>
<td>1/31/2006</td>
<td>I am concerned about her cognitive level, although not her care of ___ at this time</td>
</tr>
<tr>
<td>1/31/2006</td>
<td>GI - On blenderized foods. This diet not previously documented.</td>
</tr>
</tbody>
</table>
Schoolyard taunts: 2010

Haha! your mom blogs about you!

Shut up.
Care taker blogs in *caregiver fabricated illness in a child*: A window on the caretaker’s thinking?☆

Ana N. Brown a,1, Gioia R. Gonzalez a,1, Rebecca T. Wiester a,b,1, Maureen C. Kelley c,d,2, Kenneth W. Feldman a,b,*

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a Children’s Protection Program, Seattle Children’s Hospital, Seattle, WA, USA
b Department of Pediatrics, General Pediatrics Division, University of Washington School of Medicine, Seattle, WA, USA
c Truman Katz Center for Pediatric Bioethics, Children’s Research Institute, Seattle Children’s Hospital, Seattle, WA, USA
d Department of Pediatrics, Bioethics Division, University of Washington School of Medicine, Seattle, WA, USA
Common Patterns

- Distortion
- Escalation
- Attention (followers, donations, sharing)
- Exposure of children to public viewing
- Attitudes toward medical providers
What Can be Done About Detection?

• Like all other diagnoses, must be on the differential diagnosis list
  - For the chronically (intractably?) ill patient
What ELSE Can Be Done to Improve Detection?

A Preliminary Screening Instrument for Early Detection of Medical Child Abuse
Mary V. Greiner, Vincent J. Palusci, Brooks R. Keeshin, Stephen C. Kearns and Sara H. Sinal
Hospital Pediatrics 2013;3;39
DOI: 10.1542/hpeds.2012-0044
# Screening Tool

## TABLE 2 MCA Screening Instrument (15-Item)

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<td>Caregiver has features of Munchausen syndrome (multiple diagnoses, surgeries, and hospitalizations, with no specific diagnosis)</td>
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</table>
### Useful Characteristics of MCA

<table>
<thead>
<tr>
<th>Caregiver</th>
<th>Patient</th>
<th>Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal history of abuse</td>
<td>Care at &gt;1 hospital</td>
<td>Vomiting or diarrhea without diagnosis</td>
</tr>
<tr>
<td>Request to leave hospital AMA or by transfer</td>
<td>Consultation with &gt;1 subspecialist</td>
<td>Bruising of face and neck (suffocation)</td>
</tr>
<tr>
<td>Request for apnea monitor</td>
<td></td>
<td>Toxic or erratic drug levels</td>
</tr>
<tr>
<td>Features of Munchausen syndrome and mental illness</td>
<td>Illness abatement away from caregiver</td>
<td></td>
</tr>
</tbody>
</table>

---

**Features of Munchausen syndrome and mental illness**

Illness abatement away from caregiver
Screening Tool

Use suggested in children with apnea, chronic vomiting or diarrhea, or seizures that do not respond to conventional treatment.

Sensitivity 94.7
Specificity 95.6
Other Obstacles…Do You Participate in an Investigation?

- Practitioners experience distress about these cases!

- Is it ethical to
  1. share extensive details of the child’s medical history
  2. provide information about treating/referring physicians

  to a series of caseworkers and law enforcement investigators?
• Yes, it is

• Because you are disclosing information to them for the purpose of child safety and protection
Texas Occupations Code 159.004

• 159.004. EXCEPTIONS TO CONFIDENTIALITY IN OTHER SITUATIONS.

• An exception to the privilege of confidentiality in a situation other than a court or administrative proceeding, allowing disclosure of confidential information by a physician, exists only with respect to the following:

1. a governmental agency, if the disclosure is required or authorized by law

2. medical or law enforcement personnel, if the physician determines that there is a probability of:
   - (A) imminent physical injury to the patient, the physician, or another person; or
   - (B) immediate mental or emotional injury to the patient
HIPAA and the “Minimum Necessary Standard”

Reasonable efforts to limit the amount of protected health information that the physician uses or discloses to the minimum amount that is necessary to accomplish the purpose of the use or disclosure.

Practitioner Dilemmas:

• Is it ethical to have a consultant for child abuse involved covertly? (without parents’ knowledge)

• Is it ethical for the previously uninvolved consultant to have unrestricted access to the chart of a patient they have never seen?
YES!

• Because other consultants are involved to assist the referring provider in the diagnosis and treatment of the child

• In MCA cases, the covert nature of the evaluation is also for child safety and protection → to avoid escalation of abuse
Minimum Necessary Standard

Does **NOT** apply when a provider

- Discloses information to another provider for treatment purposes
- Requests information from another provider for treatment purposes

Minimum Necessary Standard

Should NOT interfere with a physician's ability to provide appropriate treatment to patients.

Is there a TEST to prove MCA?

Yes!
Therapeutic Separation

Factitious disorders 1
Early recognition and management of fabricated or induced illness in children

_Lancet_ 2014; 383: 1412-21

Christopher Bass, Danya Glazer

---

**Figure:** The inter-relationship between mother, doctor, and child
Therapeutic Separation

Factitious disorders 1
Early recognition and management of fabricated or induced illness in children

Lancet 2014; 383: 1412–21

Christopher Bass, Danya Gleave

*Figure*: The inter-relationship between mother, doctor, and child
Case Results

• Happy little girl in school setting, flourishing

• Eats (voraciously) with her mouth

• Normal growth

• No lines/tubes

• +Sequelae: thrombus from CVC, scars, psychotherapy
Outcomes? What Is Known?

Just A HILL OF BEANS
A Familiar Solution

Declare the past, diagnose a patient, foretell the future, practice these acts. As to diseases, make a habit of two things – to help, or at least do no harm.

—Hippocrates (Epidemics, Book I, section XI)