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SCIENTIFIC LETTER

Suspected abuse in the emergency room: Appropriateness of consultations☆

Sospecha de maltrato en urgencias: adecuación del tipo de consultas

Dear Editor:

Child abuse is a social and health problem that no one can ignore. In recent years, awareness of this issue has increased, leading to a rise in the number of reported cases and the proportion of patients arriving at hospital emergency departments (EDs) with this suspected diagnosis.[1] However, as reflected in the current protocols on child abuse,[2] EDs should not be the entry point to the health care system in most of these cases. Management at the ED is only indicated in situations requiring immediate medical attention.[2] However, there is a general feeling in EDs is that many of the suspected cases of child abuse managed in this setting do not fulfil this criterion. The aim of our study was to determine the prevalence of suspected child abuse cases managed in the ED setting in which initial management could have taken place out of hospital.

The study had a retrospective, observational and descriptive design. We included visits of patients aged less than 18 years managed at the ED of a tertiary care women's and children's hospital in which child abuse was suspected that took place during a 4-year period (January 2019–December 2022). We reviewed electronic health records after obtaining the approval of the Research Ethics Committee of the hospital (code PIC-31-21). We collected data on the following variables: age, sex, type of abuse, day and time of visit and point of origin. According to the protocol for the management of child and adolescent abuse in the health care system,[2] we considered the hospital-based care pathway appropriate if the patient urgently required medical attention or protection and/or there was a risk that evidence could be lost. If none of these criteria applied but the family self-referred to the ED, we also considered the hospital-based care pathway appropriate for the case, with the qualification that out-of-hospital management would have been appropriate. If neither of these conditions applied, that is, when there was no clear need for hospital resources and the patient was referred from other levels of care or institutions, we considered the care pathway inappropriate. The data were analyzed with the IBM SPSS Statistics software for Windows, version 29. We summarized categorical variables as absolute frequencies and percentages and continuous variables using the median and interquartile range. We compared these data according to care pathway appropriateness (χ^2 test, contingency tables). Statistical significance was defined as a *P* value of less than .05.

The sample included a total of 743 cases (46 per 100 000 visits; 95% CI, 43–49 per 100 000) with a median age of 9.8 years (IQR, 4.6–14.1), 329 (44.3%) aged more than 11 years and 564 (75.9%) female. Table 1 shows the characteristics of the visits, overall and according to their appropriateness. In 396 cases (53.3%), the family self-referred, in 41 cases (5.5%) the suspicion arose in the emergency department and 306 patients (41.2%) were referred from other care settings.

Our study shows that a considerable number of patients presenting to the ED with suspected child abuse could have received initial care out of hospital, chiefly on account of visits due to suspected sexual assault. It should be noted that sexual assault was the most common type of abuse in our study sample, in which the distribution of managed cases by type of abuse differed from the nationwide distribution in Spain,[3] where neglect and emotional abuse are most prevalent. This may be related to the setting of our study, as EDs tend to manage cases requiring immediate medical attention,[2] which usually involve physical or sexual abuse. Notwithstanding, cases of sexual assault seemed to be overrepresented compared to the study published by Solis et al.,[4] which was also conducted in a Spanish ED. This could be partly explained by the difference in age range, as their study included patients aged up to 16 years, while our sample included patients up to 18 years, resulting in a larger proportion of adolescents, who are the main victims of acute sexual assault. In addition, our hospital has pioneered care for pediatric victims of sexual abuse or assault, which may have contributed to an increased volume of these cases in our ED, even if they did not follow the established care pathways. Thus, we found that these cases accounted for nearly

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Table 1 Characteristics of emergency care visits due to suspected abuse according to appropriateness.

Characteristics	Total visits (n = 43)	Care pathway appropriateness			*P*
		Appropriate hospital (n = 385)	Appropriate out-of-hospital (n = 287)	Not appropriate (n = 71)	
Type					<.001
Sexual	458 (61.6%)	176 (45.7%)	217 (75.6%)	65 (91.5%)	
Physical	233 (31.4%)	175 (45.5%)	52 (18.1%)	6 (8.5%)	
Neglect/Emotional	52 (7%)	34 (8.8%)	18 (6.3%)	0	
Night visit (8 pm-8 am)	298 (40.1%)	163 (42.3%)	107 (37.3%)	28 (39.4%)	.414
Weekend visit	181 (24.4%)	104 (27%)	71 (24.7%)	6 (8.5%)	.004
Referred patient	306 (40.5%)	162 (42.1%)	79 (27.5%)	65 (91.5%)	<.001

all the cases classified as inappropriate and three fourth of cases in which the use of ED services was considered appropriate but could have been managed out of hospital. All of these cases were of non-acute sexual abuse, in which the ED merely acts as an intermediary between the patient and the professionals responsible for managing the case. It is to be expected that the application of the Barnahus model[5] for the comprehensive management of sexual assault in Spain will decrease this source of demand. It would be interesting to carry out surveillance to determine the impact of implementing this model on ED visits in upcoming years.

Among the limitations of the study, apart from those intrinsic to a single-center retrospective study, we ought to mention that the study period included the years of the COVID-19 pandemic, during which access to various health care resources was restricted, a circumstance that may have affected the volume of ED visits.[6]

In conclusion, although most ED visits for suspected abuse could be considered appropriate, nearly half of the total cases should have been managed in other care settings. Care pathways and criteria for the management of suspected abuse should be standardized and knowledge of the resulting model subsequently disseminated to minimize secondary victimization of patients.

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Declaration of competing interest

The authors have no conflicts of interest to declare.

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