

MOCA-PBR

MOCA-PBR STUDY GUIDE & TEST COMPANION

2026
EDITION

www.pediatricsboardreview.com

100% Money Back Pass Guarantee • Powerful Mnemonics
Massive Online Community • Board-Focused Content
Efficient Learning So You Can Enjoy Life And Have More Fun!

Written by Ashish Goyal, MD

© Pediatrics Board Review Inc

MOCA-PBR

Trusted by 10,000+ Pediatricians
Over 15+ Years.

Find the right answers quickly...
Pass MOCA-Peds in 3 years...
Get a two-year break...

[Start Your Free Trial.](#)

Money Back Quarterly Pass Guarantee

LEARNING OBJECTIVE

TOPIC 6: Child Abuse (Physical) – Recognize and evaluate findings of physical child abuse and distinguish from accidental trauma

Recognize and evaluate findings of physical child abuse and distinguish from accidental trauma

JUMP TO SECTION

- Background
- Differential Diagnosis
- Identification and Recognition of Physical Abuse
- Evaluation and Diagnosis
 - Initial Evaluation Algorithm for Suspected Physical Abuse
- Management
- Just In Case

Background

Physical child abuse is injury inflicted upon a child by a parent or caretaker. Recognition is essential because abused children returned to an abusive environment are at **high risk for repeated maltreatment and death**. The core skill tested is **injury pattern recognition**: distinguishing **abusive from accidental trauma** based on injury characteristics, location, and developmental plausibility.

Differential Diagnosis

The differential diagnosis includes **abusive injury**, **accidental trauma**, and **medical mimics**. The presence of **multiple injury types** (e.g., bruises plus fractures) **strongly suggests abuse** because mimics typically cause only one finding type. A medical condition that mimics abuse **does not exclude concurrent abuse**.

TABLE 1: KEY FEATURES DISTINGUISHING ABUSIVE FROM ACCIDENTAL INJURY

INJURY TYPE	MORE CONCERNING FOR ABUSE	MORE CONSISTENT WITH ACCIDENTAL
Bruises	TEN locations (torso, ear, neck) in child <4 years ; patterned (loop, belt, hand); any bruise in infant <6 months ; multiple bruises in non-mobile infant	Over bony prominences (shins, knees, forehead); single bruise in mobile child; location matches developmental stage
Burns	Immersion scald with sharp “stocking/glove” demarcation; symmetric bilateral burns; perineum/buttocks involvement; contact burn shaped like object (iron, cigarette)	Splash/spill pattern on anterior body; irregular borders; palm burn from grabbing hot object
Fractures	Metaphyseal corner (bucket handle); posterior rib fractures; multiple fractures in different healing stages ; long bone fracture in non-ambulatory infant	Isolated linear skull fracture with witnessed fall; clavicle fracture; toddler fracture (spiral tibia) in ambulatory child
Intracranial	Subdural hematoma in infant <12 months without high-energy mechanism; associated retinal hemorrhages ; no witnessed trauma	Epidural hematoma with witnessed fall; documented high-energy mechanism (MVA)
Abdominal	Duodenal hematoma or perforation ; pancreatic injury in child <4 years without high-energy mechanism; delayed presentation	Splenic or hepatic injury with witnessed high-energy trauma; handlebar injury with visible external bruising

Medical mimics (typically cause single finding type only):

- **Bleeding disorders** (bruising, intracranial hemorrhage)
- **Bone fragility disorders** (fractures)
- **Skin conditions** (congenital dermal melanocytosis, phytophotodermatitis)
- **Cultural practices** (cupping, coining)

Identification and Recognition of Physical Abuse

Red Flag History:

- No history despite severe injury
- **Implausible mechanism** for injury type or severity
- **Delay in seeking care**
- History **changes with retelling** or **conflicts between caregivers**
- Injury blamed on young children or pets
- Injury attributed to resuscitation

Red Flag Physical Findings: The mnemonic **TEN-4-FACESp** identifies high-risk bruise locations (**96% sensitivity, 87% specificity**): **T**orso, **E**ar, **N**eck (if **<4 years**); **F**renulum, **A**ngle of jaw, **C**heek, **E**yelid, **S**ubconjunctival hemorrhage, **p**atterned bruises (any age **<4 years**; any bruise if **<6 months**).

Any bruising in **infant <6 months** is concerning (occurs in **<1%** of healthy non-mobile infants). **Pre-mobile children** seldom have more than one bruise; **crawlers** seldom more than two.

Physical Examination:

- View **all skin surfaces**
- Examine **oral cavity** for frenulum tears (can occur when an object is forced into the mouth to quiet a crying infant)
- Check **eyes** for subconjunctival hemorrhage
- Palpate **scalp and fontanels**
- Assess **extremities** for tenderness or deformity
- Obtain **dilated fundoscopic exam** if intracranial injury suspected. **Retinal hemorrhages are virtually pathognomonic for non-accidental trauma.**

Evaluation and Diagnosis

Initial Evaluation Algorithm for Suspected Physical Abuse

- 1 **Stabilize** immediate medical threats.
- 2 **Obtain history** from each caregiver **separately**.
- 3 Perform **complete skin examination** with attention to TEN-4-FACESp locations.
- 4 **Assess** whether injury is **inconsistent with history or developmental stage**.
- 5 If red flags present, **consult child abuse team** and initiate workup (skeletal survey, head imaging, labs).
- 6 **Report to governmental agency**.

TABLE 2: DIAGNOSTIC EVALUATION BY AGE AND PRESENTATION

PATIENT CHARACTERISTIC	RECOMMENDED EVALUATION
All patients with suspected abuse	Social work consult; child abuse specialist/team consult
Infant <6 months (any concern); infant 6-12 months with head injury or suspicious fracture; signs of intracranial injury	Head CT or MRI
All children <2 years with suspected abuse; child <5 years with neurologic impairment, distracting injury, or suspicious fracture	Skeletal survey; repeat at 2 weeks if concern persists
Infant <6 months ; trunk bruising; abdominal tenderness; altered mental status	AST and ALT; if >80 U/L, CT abdomen with contrast
Concern due to bruising or intracranial hemorrhage	CBC, platelets, PT, INR, aPTT
Suspected drug exposure	Toxicology screen

Screen AST/ALT if abdominal concern; **>80 U/L** triggers **CT abdomen**.

Skeletal survey indications:

- All children **<2 years** with suspicious injuries
- **Non-ambulatory infants** with bruises or oral injuries
- **Unexplained intracranial hemorrhage**

Management

Consult social work and child abuse team for all suspected cases. **Report to governmental agency** (mandatory in most jurisdictions).

Hospitalization is indicated for treatment of injuries and child safety. **Siblings <2 years** sharing household with abused child require **skeletal survey evaluation**.

JUST IN CASE (CURATED EXAM-DAY SUPPORT)

- [Physical Child Abuse Recognition](#) – UpToDate
- [Physical Child Abuse Diagnostic Evaluation and Management](#) – UpToDate

[↑ Back to Top](#)

MOCA-PBR

Trusted by 10,000+ Pediatricians
Over 15+ Years.

Find the right answers quickly...
Pass MOCA-Peds in 3 years...
Get a two-year break...

[Start Your Free Trial.](#)

Money Back Quarterly Pass Guarantee