In the past few years, there have been major advances in our understanding of the occurrence of child maltreatment, its diagnosis, and its long-term implications. In recognition of the growth of knowledge and expertise in the field, “child abuse pediatrics” became a board-certified subspecialty of pediatrics in 2009.

Child abuse pediatricians serve as a resource for pediatricians, families, child welfare departments, and law enforcement. Nevertheless, primary care pediatricians remain the first responders for maltreated children. It is in primary care where injuries are seen, where neglect may be noticed, and where very tough decisions are made about whether to report findings to authorities. Primary care plays the central medical role in prevention of maltreatment, and helps children find the inner resources and support they need to heal.

This issue, through the excellent contributions of some of the country’s leading authorities in child abuse pediatrics, provides useful information to support general pediatricians.

According to a survey reported by the Centers for Disease Control and Prevention (CDC) in 2010, fully 25% of adults in six states recall having been abused as children, whether physically, sexually, emotionally, or through neglect. Further, these childhood experiences have long-term negative health consequences, including high-risk health habits, disability, and death.

Neglect accounts for a large majority of cases of child maltreatment. In some cases, the neglect may be so obvious that it calls out for intervention; children may be found wandering alone, dirty, unkempt, and unattended. However, many times the clinical presentation can be subtle, and the primary care provider may struggle with deciding on a reasonable course of action to support these children and families. The article by Hiu-fai Fong, MD, and Cindy W. Christian, MD, (see page 508) provides current guidance for determining when a family situation crosses the line into neglect, and provides useful support for making clinical decisions.

Although child sexual abuse occurs less frequently than other forms of maltreatment, its effects can be devastating for both the child and the family. Martin A. Finkel, DO, FAAP, (see page 510) describes the clinical approach that should be taken when a child discloses, or a parent suspects, sexual abuse. His common sense approach, based on an extraordinary amount of experience in the field, provides a relatively straightforward clinical path in this highly emotional and difficult arena.

Although pure emotional abuse is less commonly reported than other forms of maltreatment, all maltreatment results in emotional turmoil and may lead to lifelong mental health consequences. The case-based article by Genevieve Preer, MD, and Betsy McAlister Groves, LICSW, (see page 511) outlines the clinical approach known as “trauma informed care,” and will help guide the selection of appropriate, effective therapies for children who are victims of abuse, or who have been exposed to violence in the home.

The children we care for rely on us to look out for them, to be alert to the troubles they and their families face, and to intervene. Although medical providers are only one part of society’s response to maltreatment, our privileged look inside families offers the opportunity to help.

Physicians, including primary care pediatricians, tend to under-report child abuse. In their examination of the diagnosis and management of child physical abuse, Emalee G. Flaherty, MD, and Amanda K. Fingarson, DO, (see page 512) provide a cogent argument for objective evaluation of childhood injuries and present simple diagnostic findings that should lead to an investigation of the possibility of child abuse.

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