

Infectious Diseases Still Cause for Concern

John J. Frey, III, MD, Medical Editor

For a project I am working on, I have been reading through journals from 1970, the year I graduated from medical school. What is revealing, of course, is both how much has changed and, conversely, how much is still the same. Rather than cancer, genomics, and chronic illnesses that are the subjects of today's medical literature, the clinical topics from 40 years ago focused on infection and infectious diseases. Interestingly, though, infectious diseases—both ones that were known 40 years ago and those that weren't—are still around and still cause problems. This issue of *WMJ* highlights some of the infectious diseases that are found in our region.

Two articles on tick-borne illnesses should catch readers' attention as spring and the woods beckon. To the chant that Dorothy and her friends repeated as they crept through the woods on the way to Oz—"Lions and Tigers and Bears! O My!"—we should add "and ticks." The first is a case report of a severe complication of an infection with *Anaplasma phagocytophilum* in a patient who is on a statin, creating a life-threatening condition of potential renal failure from rhabdomyolysis.¹ Fortunately a more complete history from the patient's wife secured enough of a concern to look for tick-borne disease, and the patient recovered. With the almost universal presence of statins in adults these days, it might be a good case to remember. The second article by Maloney is a review of the recommendations for diagnosis and management of Lyme disease as well as the possible transmission of *Anaplasma phagocytophilum* and *Babesiosis* via the

same ticks as the case report.² Maloney feels that the recommendations for diagnosis and treatment should be broadened to give clinicians more leeway in diagnosing and managing potential tick-borne diseases, which might decrease the potential for chronic form of Lyme disease or the more severe acute consequences of the other diseases.

Blastomycosis is not anywhere near as prevalent as Lyme disease but is a human

have previously shown, there are good reasons that they should.⁴ A family doctor friend from New Mexico got a call from his patient who had flown to the East Coast and then developed a severe illness. My friend told his patient, "Tell the doctors to look for the plague," which, of course was what the patient had—and which is less common in New York than New Mexico.

Edwards and colleagues look at the atti-

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pathogen that should be on our minds in both rural and urban areas where exposure to rivers and lakes exists. Baumgardner and colleagues, who have done work on establishing the water-borne risks for blastomycosis, show how, despite clinical scenarios that are highly suggestive of that infection, most primary care clinicians do not put it among their most likely diagnoses.³ Even when presented with clinical descriptions that are grounded in environmental situations, most clinicians have a hard time imagining diagnoses that do not fit with their usual experience. While urban doctors didn't think of blasto as frequently as rural doctors from endemic areas, perhaps, as the authors

tude of pediatricians toward immunizations and discovered some provocative data.⁵ The reassuring aspect of their study is that most pediatricians follow immunization recommendations for their patients. However, these same doctors come up short when recommending immunizations to family members of their at-risk patient. Children live in families, and the medical home for children should somehow contain the ability to deal with parents and other relatives of at-risk children. One confounder for the practicing community is that the size and location of practices affect both accessibility consistency of primary care and access to immunization. A recent article pointed

out that family doctors in small practices and rural areas did not consistently provide a high level of routine immunizations for children and adults in their practices because of cost and access to vaccines.⁶ Edwards and colleagues also point out that the continuing controversy over thimerosal-free immunizations will affect physician and patient behavior regarding adhering to national guidelines. Changing beliefs might require more work and more conversation than it has to this point.

This issue also contains a study of chest pain in adolescents by Hanson and Hokanson from the view of the consulting clinician rather than the referring clinician.⁷ Their nicely done retrospective study is very reassuring in that a good history, physical exam, a screening electrocardiogram, and an echocardiogram will help primary care clinicians distinguish adolescents who have the likelihood of a cardiac origin for their chest pain from those who don't. This study looks at a 2-year period of referrals to a pediatric

cardiology clinic, and fewer than 1% of the patients were found to have a cardiac etiology for chest pain.

Finally, Ahrens reviews the experience of lobbying around the health bill in Wisconsin that created statewide regulations eliminating smoking in workplaces.⁸ Why in 2010, one might ask, are there any arguments at all about the health effects of cigarettes on smokers or those exposed to secondary smoke? The facts did not sway a wide variety of lobbyists trying to influence the bill: the pro-tobacco groups used money and those in favor of a smoking ban used time and energy. It might be refreshing at some point to see discussion and debate about a public health problem and how best to accomplish it rather than whether it should be a goal at all.

Finally, this issue of *WMJ* contains a CME opportunity that we plan to include periodically. Readers may review the designated manuscript, in this case the Maloney article, and take the quiz for CME credit. *WMJ* Editorial Board member Richard

Reynerston, MD, has taken the lead on this idea, and we are grateful to Dick and his efforts at improving the journal.

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