Isolated elders and precocious children

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Two articles featured in this issue of *WMJ* point to some of the societal forces that affect medical practice. I often have mused that on any given day, I see patients for whom families are the support necessary for living life fully and safely and, in contrast, see patients for whom families represent unreasonable demands on time, money, and safety. Articles in this issue address both of those opposites.

The study by Thomson and colleagues[1] highlights the increased level of awareness that physicians must have about the potential for abuse and neglect of their older patients. While the focus for their study was Milwaukee County over a 4-year period using the Milwaukee County Department on Aging data, many of their findings can and should be informative for clinicians in other cities and rural areas in the state and beyond. Most practices now include smoking as a vital sign to identify patients who would like to stop smoking. Medical students and residents are taught to ask women, in confidential ways, about their safety at home and for any history of an abusive relationship. We are screening for depression far more often in primary care than in years past, as the awareness of mental health problems grows in all populations. But who of us routinely asks our elderly patients living with family or friends if they have any concerns for their own safety or for being mistreated? How many of us have information in our medical records identifying which of our older patients live alone and are able to care for themselves or know the appropriate community agency to get involved if we have concerns?

Thomson and colleagues found that the highest source for reporting possible elder abuse were physicians, which means that many of us are aware of the issues and the proper referrals. But the majority of cases were not physician-initiated, so there is still a great deal of work to do to increase practice information systems to recognize high-risk elderly.

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Klinenberg's book on the Chicago heat wave in 1995 that killed 521 people over 3 days showed that, in the end, poor, minority elders living alone were at highest risk of death.[2] I have been haunted by the thought, should another such calamity happen, of whether our practice would be able to identify patients who need services that would prevent them from dying alone.

US census projections are that, by 2050, 1 in 5 Americans will be over 65. The plains states and upper Midwest have the highest concentration of elderly, according to the 2010 census, and the number of elderly in those states undoubtedly will continue to grow.[3] The most rapidly growing population is what is termed the "oldest old," or people over 85. Census data show that 50% of people in this demographic need assistance for activities of daily living, and it's likely that the prevalence of self-neglect or abuse in our older patients will only grow. The real question is whether physicians in communities are prepared to recognize, report, and begin to set up systems to respond to situations we encounter in an increasingly challenging population.

A parent—or grandparent—regularly reading to their children or grandchildren has long been noted to influence the acquisition of language and reading skills.[4] Sometimes we have the startling experience of the child suddenly reading to us. Treffert's article in this issue[5] addresses the increasing complexity of working with hyperlexic children and their parents. Hyperlexic children often have "autistic behaviors" and, in a world where autism has been more widely described since the mid-20th Century, raise concerns for families about their children's behaviors. Treffert describes 3 types of hyperlexia, not to create yet more ways of medicalizing behaviors, but to show the range of people who are often termed "precocious." They range from early readers, who in past years may have been labeled "gifted" rather than a "problem," to children who exhibit social and behavioral awkwardness—and in some cases, late speech development—but who are exceptionally smart, particularly with words.

I confess a substantial reluctance to label behaviors as "diseases," because labeling has long had potential for creating terrible consequences for individuals and societies—whether for their health insurance premiums or their job security. Just as Gardner described intelligence as having a wide variety of forms rather than a single term that was used for academic performance,[6] Treffert describes a typology of hyperlexia that doesn't penalize children with labels that affect many components of their lives. This, in the long run, is a good thing for everyone involved—parents, children, teachers, and physicians.

This issue also contains a 4-year cohort study by Poola and colleagues[7] looking at the natural history of subclinical hyperthyroidism, emphasizing a "wait and watch" philosophy that should guide clinicians who have patients with low thyroid-stimulating hormone TSH levels, normal T4 and T3 levels and no demonstrable nodules. Two case studies, one on an unusual consequence of an unusual tickborne illness[8] and a pericarditis relating to smallpox vaccines received by 2 soldiers[9] teach us to look for relationships that often are not the first choice in a differential diagnosis. Zebras do happen.

Finally, "The Depravity of Youth," an editorial published in *WMJ* 104 years ago, raises 4 questions about sex education in schools. While the editorial position from 1907 was quite different than would be the case today—most of us wouldn't see giving girls education about sex producing "vicious habits" as the former editors mention—who educates, where it occurs, and what the role of physicians should be still form part of the discussion about that issue in 2011.

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