Elder abuse: Dermatologic clues and critical solutions

Matthew Palmer, BS,[a] Robert T. Brodell, MD,[c,d] and Eliot N. Mostow, MD, MPH[a,b]
Rootstown and Cleveland, Ohio; and Rochester, New York

Elder abuse affects approximately 2% to 10% of older Americans. Unfortunately, it is often unrecognized and certainly underreported. Dermatologists have a unique role in the detection and reporting of elder abuse. An analysis of risk factors, clinical signs, reporting requirements, and prevention of elder abuse brings this issue into focus. (J Am Acad Dermatol 2013;68:e37-42.)

Key words: abrasions; bruising; burns; decubitus ulcers; elder abuse; geriatrics; lacerations; traumatic alopecia.

Elder abuse is not new, having been documented in ancient Greek literature and Shakespeare's *King Lear*.[1-3] Surprisingly, elder abuse ("granny battering") was not described in medical literature until 1975 and the dermatology literature in 1992.[4-6] Elder abuse is a significant problem with adult children and spouses being the most common abusers.[7] The vulnerability of our elders is demonstrated by the estimated annual incidence of abuse and neglect at 2% to 10%.[8] In other words, if a dermatologist sees 20 to 40 older individuals per day in his/her clinical practice, at least one may be a clinical or subclinical victim of elder abuse.[9] It has been estimated that for every reported case of elder abuse, 5 more go unreported.[10] Of cases reported to Adult Protective Services (APS), only 1.4% of reports come from physicians.[11]

Individuals older than 65 years are currently 12.97% of the US population and are expected to increase to 19.30% by 2030.[12] An increasing number of elderly patients would be expected to result in even greater numbers of abuse cases. This may be especially true if a limited number of caretakers are responsible for the care of a burgeoning population of elderly individuals. Because elder abuse has been associated with increased mortality, the significance of the problem extends beyond pain and suffering.[13]

From the Northeast Ohio Medical University, Rootstown[a]; Case Western Reserve University School of Medicine, Cleveland[b]; and University of Rochester School of Medicine and Dentistry, Rochester[c]; University of Mississippi, Jackson.[d]

Funding sources: None.
Conflicts of interest: None declared.

Reprint requests: Eliot Mostow, MD, MPH, Northeast Ohio Medical University, 157 W Cedar St, Suite 101, Akron, OH 44307. E-mail: emostow@neomed.edu.

Published online October 10, 2012.
0190-9622/$36.00
© 2011 by the American Academy of Dermatology, Inc.
doi:10.1016/j.jaad.2011.03.016

Dermatologists are in an uncommon position, caring for a broad range of ages, with many elderly patients developing skin problems that result in skin examinations that might also point to signs of elder abuse. Clearly, if one is not thinking about the problem, it is less likely to be identified and we hope that this review will close this clinical gap in knowledge.

TYPES OF ABUSE

Elder abuse was defined by the US National Academy of Sciences in 2002 as "(a) Intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended), to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder, or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm."[8] Several types of elder abuse have been outlined[10]:

1. Physical abuse—use of physical force that may result in bodily injury, physical pain, or impairment.
2. Sexual abuse—nonconsensual sexual contact of any kind with an elder.
3. Emotional abuse—infliction of anguish, pain, or distress through verbal or nonverbal acts.
4. Neglect—refusal or failure to fulfill any part of a person's obligations or duties to an elder.
5. Self-neglect—behavior of an elder that threatens his/her own health or safety.
6. Abandonment—desertion of an elder by an individual who has assumed responsibility for providing care for an elder.
7. Financial or material exploitation—illegal or improper use of an elder's funds, property, or assets.

RISK FACTORS: RAISING THE INDEX OF SUSPICION

There is evidence to support an association of several risk factors with elder abuse. First, a shared living situation leads to increased opportunities for conflict and tension (a notable exception being financial abuse in which the majority of victims live alone). Second, dementia is often associated with aggressive and disruptive behavior that may provoke caregivers to retaliate. Finally, social isolation from friends and relatives is clearly associated with an environment conducive to abusive situations.[9] Impairment of an individual's health and functional status appears to be less consistently associated with elder abuse, nor has the degree of dependency of the abused on the caretaker been shown to be a risk factor.[9]

CAPSULE SUMMARY

- Abuse is a significant problem effecting elders. Recent research has demonstrated risk factors and clinical signs. Early recognition and prevention are critical to abused elders.
- It is important to elevate elder abuse in the differential diagnosis of many dermatologic conditions.
- Early diagnosis can prevent associated morbidity and mortality.

THE DIAGNOSIS OF ELDER ABUSE: SYMPTOMS AND SIGNS

There are no pathognomonic signs of elder abuse. In many ways the findings are similar to those seen in child abuse, although the fragility of aging skin and more common use of aspirin and other anticoagulant medications in the elderly can lead to more pronounced bruising. When confronted with the possibility of elder abuse, it is important to consider whether an injury is truly suspicious for abuse or accidental in nature. When possible, a history should be obtained from the patient regarding how a suspicious lesion occurred. It must then be determined if this mechanism correlates with the appearance of the lesion in question. Psychosocial elements must also be assessed. Important considerations are age-related changes that make the skin more vulnerable to injury.

The types of abuse that result in physical injuries are physical abuse, sexual abuse, and neglect. In each of these situations, signs of injury can be described with regard to patterns of injury and patterned injury. "Patterns of injury" refer to injuries sustained with a typical behavior (ie, contusions on ulna when defending oneself). "Patterned injuries" are those where soft-tissue imprints are caused by an object striking the patient leaving a characteristic pattern (eg, iron or cigarette burns, knit pattern of sweater on skin after blunt force blow, bite patterns).

PHYSICAL ABUSE

Bruising

See Table I. Bruising is the physical marker that has been the focus of the most research with regard specifically to elder abuse. Most physically abused elders have bruising.[14] However, certain characteristics of bruising raise the suspicion for abuse including bruises larger than 5 cm or those located on the face, side of right arm, or back of torso.[14] Blunt trauma from an open hand or objects such as shoes, belts, or canes can result in patterned injury.[15] Another commonly seen pattern is that of fingertip-patterned bruising as a result of restraint (Fig 1). Bruising inflicted by a punch is common on the face, breast, chest, abdomen, or extremities and resembles the shape of a fist with an area of central clearing.[16] When assessing a bruise it is important to consider that the color of a bruise is not indicative of its age.[17]

Bruising also commonly results from accidental trauma with 90% of accidental bruising found on the extremities. It is rarely found on the neck, ears, genitalia, buttocks, or soles of the feet (Fig 2). Thus, bruising in these uncommon areas is suggestive of abuse. Individuals taking medications that act on coagulation are more likely to have multiple bruises. However, these medications have no effect on size or time to resolution of bruising. Those who require assistance with activities of daily living are also at risk for multiple accidental bruises.[17]

Some conditions produce cutaneous findings that mimic abuse. Bateman purpura (senile purpura or solar purpura) commonly occur on the extensor surfaces of the forearm in the setting of chronic photodamage. This is a result of the degeneration of extracellular matrix components leaving dermal capillaries unsupported and susceptible to injury (Fig 3).[18] Similarly, steroid purpura appear in areas chronically treated with topical steroids as a result of the atrophogenic effects of these drugs.[19] Systemic steroids are also associated with purpura usually in areas of sun exposure or after mild trauma.[20] In both cases, the skin may also be fragile and tear easily. These phenomena differ from the sequelae of abuse because they are restricted to the areas of chronic sun damage and steroid application, respectively.

Download English Version:

https://daneshyari.com/en/article/3205661

Download Persian Version:

https://daneshyari.com/article/3205661

Daneshyari.com