DIAGNOSING ELBOW PAIN

To the Editor:

I am writing to express my concern over a case report published in the July 2004 issue of *Hospital Physician* entitled "An Unusual Presentation of Multiple Myeloma" by Drs. Komodromos and Levinson.[1]

Lateral epicondylitis is an overuse syndrome seen most often in middle-aged recreational athletes. It is caused by repetitive tension overloading of the wrist extensor origin, leading to a degenerative tendinosis. The clinical presentation of a 71-year-old gentleman with new, progressively intense elbow pain following an acute episode is not consistent with this diagnosis, and other possible disorders should have been entertained in the differential diagnosis. Based on the plain radiographs taken 3 months after the patient's initial presentation (which demonstrated a large aggressive lytic lesion in the proximal radius, along with a pathologic fracture), a detailed physical examination of this patient would likely have been notable for tenderness over the proximal radius, increased by pronation and supination. Soft tissue swelling might have been palpable in this region secondary to hematoma formation following a pathologic fracture or the tumor itself. Most likely, the lateral epicondyle would not be the site of maximal discomfort. Knowledge of musculoskeletal surface anatomy is necessary in localizing the site of injury based on examination. Unfortunately, this skill is frequently neglected or inadequately taught during medical school education.

Yet, even without being comfortable with the musculoskeletal examination, the proper diagnosis could have been made if adequately training was provided on how to conduct the evaluation of a musculoskeletal complaint. Possibly the most basic tenet of orthopaedics is the role of plain radiographs in the evaluation of musculoskeletal pain. Anterior-posterior and lateral views of the elbow taken at presentation would most certainly have demonstrated the underlying pathology 3 months earlier, when the lesion was smaller and easier to address. Even if radiographs were not obtained at presentation, there was still a possibility of correcting this crucial and neglected aspect of the work-up when the patient returned for follow-up 2 weeks later. Despite the interventions of nonsteroidal anti-inflammatory drugs, rest, and a compressive wrap, the patient failed to improve. Basic medical logic offers 2 possibilities—either the diagnosis was wrong or the interventions were not effective. Before sending the patient to physical therapy for 3 months, the treating physician should have re-examined the patient, re-evaluated/expanded the differential diagnosis, and considered further diagnostic modalities including the plain radiographs that were not obtained initially. Thus, at multiple levels and times, the proper diagnosis was missed.

A 3-month delay in the diagnosis of a pathologic fracture and multiple myeloma can adversely affect a patient's quality of life and confidence in the medical system as a whole. If one is not familiar with how to properly initiate the evaluation of a given clinical situation, the underlying pathology can remain elusive. This is especially true for musculoskeletal disorders. I believe that this case report demonstrates a larger problem in our medical education system. It is unfortunate that we do not dedicate a larger proportion of medical school and residency training to this commonly seen area of medicine.

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References

1. Komodromos T, Levinson DJ. An unusual presentation of multiple myeloma. Hosp Physician 2004;40(7):35–8.

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