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Editorial

Limited Basic Knowledge by subspecialists in orthopaedic surgery

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There is no question that subspecialization has increased the quality of care in many areas of orthopedic surgery. Many surgical procedures done by subspecialists are done more efficiently or superiorly by those with specific expertise.

However, a major flaw exists among many orthopedic subspecialists in that many have forgotten how to diagnose other conditions. There are practices where a person who sustains an auto accident with injuries to several areas needs to see several doctors for basic diagnoses and care. Why should this be needed when all of us made these very same diagnoses when we were first year residents? If you are a sports specialist, have you forgotten how to examine a spine? Do you not know how to diagnose carpal tunnel syndrome? If you are a spine specialist, do you not know how to examine a knee? These are only a few examples of things I have been seeing in recent years.

Any orthopedic surgeon should be able to make fundamental diagnoses and know how to examine the musculoskeletal system. A spine surgeon should know how to examine a knee or a hip and he should certainly know dermatomes. I have several anecdotes that are inexcusable.

Case number one

A patient has an auto accident and has neck and arm pain. He has numbness and tingling in his ring and small fingers. A spine surgeon fuses C5-6. I saw the patient subsequently as he still had numbness and tingling. He had an ulnar nerve entrapment at his elbow. I did a cubital tunnel decompression and his pain resolved. Did the spine surgeon not know that C5-6 affects the C6 root which goes to the thumb and index fingers. The ring and small fingers are general affected by the C8 root or the brachial plexus or the ulnar nerve. The patient had a markedly positive Tinel's sign at his elbow when I saw him. So, the cervical surgery was not indicated on a neurological basis.

Case number two

A different spine surgeon of significant repute recommended a fusion at L4-5. The patient had severe hip pain and when I examined him, he had no rotation at his hip. X-rays demonstrated severe degenerative arthritis of the hip. I performed a total hip replacement and all his pain resolved. Thankfully, he was spared a lumbar fusion.

Case number three

A spine surgeon performed a lumbar fusion. The patient did have severe back pain. Z-rays show a large renal calculus. Spine surgery does not relieve the pain of a kidney stone. The patient had his issue addressed by a urologist but has continuing back pain from the residuals of the lumbar fusion.

Similarly, a patient seen by an extremity or sports or joint specialist should be able to rely on that orthopaedic surgeon to diagnose spine pathology or nerve entrapments. Any orthopedic surgeon should be able to determine whether a patient needs an MRI or EMG,

nerve conduction study, or other X-rays or studies. I have no problem with referrals to subspecialists and encourage this but the early evaluation of an injured patient or a patient with several conditions should not require an immediate referral to multiple physicians with specific clinical indications. We learned how to do this early in our residency training as the knowledge is fundamental.

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