The now popular and 'fashionable' carpal tunnel syndrome – revisited

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During my residency and first years of practice in the late 60s and early 70s, it was not unusual to see patients with neglected hands with obvious wasting of the abductor pollicis brevis muscle, clumsiness, weakness and loss of sensation in the median nerve distribution. It was common practice to add some type of opponens tendon transfer to the carpal tunnel release procedure – frequently the Camitz procedure.

During the past two decades the situation has changed drastically. The condition has now become 'popular' with family doctors, patients, coworkers, lawyers and others.

Previously, we had to educate the public in early recognition of this condition. Now our problem is to make the correct diagnosis! Since my 'semiretirement' and since becoming a 'hand physician' (a plastic surgeon who does not operate but sees only hand patients), almost every patient with some type of tingling and pain in any finger is referred with the diagnosis of 'carpal tunnel syndrome'!

So, why this change?

I would like to offer some suggestions.

The family physicians in our area (Toronto, Ontario) are generally very busy and often do not have the time to go into the details of the history, order an electromyogram and nerve conduction study, which most of the time are positive, and refer the patient. And, while I am on this subject, I have never had much use for these tests – with some exceptions. I used to operate on patients with definite positive provocative tests and failure of conservative management. I have been known to state that, "I do not operate on x-rays or EMGs, only on hands!" However, they are helpful in the diabetic patient with peripheral neuropathy and, in some individuals, with the 'double crush' syndrome (ie, carpal tunnel syndrome and cervical radiculopathy).

The tests may also be required by some third parties such as the Workplace Safety & Insurance Board of Ontario or insurance companies.

There are several problems with these studies:

1. They quite often do not correlate with the physical findings.

2. They are highly subjective and the results can differ among laboratories (even the normal values).
3. Most of the symptoms happen during the night but the tests are performed during the day when the patient may be symptomless.
4. My biggest objection, however, deals with the report, which is quite often shown to the patient and states that the patient requires an operation!

What can we do about it?

We should present our thoughts and opinions in postgraduate presentations, rounds and talks to the medical students.

THE WORKPLACE, WORKER AND COMPENSATION

Although repetitive activities in factories and offices have been with us for many years, it seems to me that, because these jobs are often boring, many people look for ways to get out of them, or to get compensation. We all know that there are significant differences of opinion whether repetitive activities are the cause for carpal tunnel syndrome, or indeed, qualify for compensation. Although workplaces may not have changed significantly, I think the worker has.

It is not uncommon for me to see the young or middle-aged worker, often a woman, who is overweight, has a short neck, poor posture and carpal tunnel syndrome-like symptoms. More often than not, the work station is ergonomically improperly designed. We, as hand surgeons, have a duty to assess the whole patient and the workplace, make the correct diagnosis and, if necessary, suggest changes either in life style or the workplace.

THE SURGEON

Unfortunately, as one of the hand consultants for our provincial Workers' Compensation Board (Workplace Safety & Insurance Board of Ontario), I still see a number of patients who have not improved following a carpal tunnel release. After a complete examination, it seems the preoperative

diagnosis was missed and most of the symptoms were arising from the neck. It is therefore important for us to examine the patient with provocative tests for thoracic outlet syndrome and cervical radiculopathy. I do realize that thoracic outlet syndrome is a controversial diagnosis, but I believe that the condition does exist and may present in different forms. I prefer to call it 'irritable brachial plexus syndrome'. The treatment is by specific neck physiotherapy.

Therefore, it is important for us to address the whole situation – a look from the outside of the box – before offering an operative solution.

We must have someone carry out an ergonomic assessment of the work station, order physiotherapy for the neck problem, suggest weight loss if indicated, and even suggest the possibility of a job change or modified duties on a permanent basis. I must say that I am very skeptical that patients with the above conditions, after a successful carpal tunnel release, are able to return to repetitive activities! It is therefore wiser to offer surgery after a significant job change, if the symptoms still persist.

I realize that some of these thoughts are controversial, but that is the beauty of expressing them in an editorial.