Letter to Editor: Rediscovering the Art of Clinical Examination in the Era of Super-Specialisation

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Dear Editor

The authors of the case report regarding "Isolated Flexor Tenosynovitis as the Sole Manifestation of Rheumatoid Arthritis" have discussed with great clarity that a high index of suspicion and a multidisciplinary approach are key in managing atypical presentations of seronegative RA.[1] In the mentioned case of isolated wrist swelling in a 44 year old male, during clinical examination, the authors didn't mention doing a detailed systemic examination to look for associated extra articular manifestations of inflammatory arthropathy eg- Rheumatoid arthritis has pulmonary, cardiac, GI or eye manifestations, which are known to occur in a case of inflammatory arthropathy.[2]

Although in the discussion part, the authors have mentioned that in the discussed patient, the negative rheumatoid factor and lack of systemic RA features delayed the consideration of an inflammatory etiology. They have well recognised that while rheumatoid factor and anti CCP antibodies are useful diagnostic tools, their absence does not exclude the disease.[3,4]

Orthopaedic Surgeons and super specialists as a community have stopped examining patients as a whole and have started restricting the detailed clinical examination to musculoskeletal system only. This may be due to multiple reasons such as:[5] 1. haste of examining more patients timely in a busy clinical practice (time constraints) or

2. lack of interest in diagnosing the patient as a whole rather than a joint specific diagnosis or

3. lack of proper knowledge regarding the multiple systemic involvement of any specific disease such as inflammatory arthritis.

4. Lack of confidence in one's clinical examining capabilities

5. Improvement in technology, have shifted the focus on more laboratory or radiological tests.

In contemporary clinical practice, orthopaedic surgeons are increasingly confronted with patients presenting with complex, multi-joint arthritis and chronic back pain. These conditions often coexist with systemic manifestations, particularly in inflammatory arthritis, where multiple organ systems may be involved.[2] Despite this, the current trend of super-specialisation has led to a narrowing of clinical focus, where physicians often confine their attention solely to their domain of expertise—for example, a "knee specialist" evaluating only the knee joint. This compartmentalisation, while advancing expertise, risks fragmenting patient care.

A parallel shift is also evident in the growing reliance on imaging modalities and laboratory investigations. Magnetic resonance imaging (MRI), X-rays, and serological panels have undoubtedly revolutionised diagnostic accuracy, yet their overdependence has come at the expense of the most

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fundamental clinical tool—the bedside examination. Increasingly, patients are subjected to referrals across multiple specialties without a holistic clinical evaluation, resulting in unnecessary investigations, heightened financial burden, and, paradoxically, delayed diagnosis.

Traditionally, medical training emphasized a thorough general and systemic clinical examination. Physicians were trained to observe, palpate, and auscultate—not only the site of presenting symptoms but also other organ systems, recognising that diseases seldom respect boundaries of medical specialisations. For example, arthritis patients may demonstrate silent involvement of cardiac, pulmonary, or gastrointestinal systems, which can easily be missed without a deliberate and structured approach to systemic evaluation. Early identification of such manifestations is not merely academic; it is crucial for initiating timely management, preventing morbidity, and improving quality of life.

The responsibility of holistic examination does not vanish with super-specialisation. Every physician, including orthopaedic surgeons, is trained during undergraduate and internship years in comprehensive clinical methods. These skills must not be relegated to history. An orthopaedic consultation should not be limited to the musculoskeletal system alone; rather, it should incorporate a basic screening of other systems. Only then can referrals be judicious—guided by findings rather than routine practice.

Failure to perform this essential step risks misdiagnosis, inappropriate referrals, and an escalation of healthcare costs—challenges particularly pressing in resource-constrained settings. Moreover, a clinical diagnosis rooted in careful examination fosters patient trust and demonstrates the physician's attentiveness, often forming the cornerstone of the therapeutic alliance.

In the referred case report, had a detailed clinical general examination along with system examination revealed anything supporting the diagnosis of inflammatory arthropathy like seronegative rheumatoid arthritis, and if any supporting further investigation pertaining to that clinical examination would have been conclusive, the patient could have been treated medically with DMARDs and other anti-rheumatoid drugs, potentially treating the wrist pain due to the pathology of flexor tenosynovitis. This would have avoided the surgical intervention of excision biopsy and synovectomy in the said patient.

In the current climate of technological advancement and super specialised practice, it is imperative to reaffirm the value of clinical examination as the foundation of good medical practice. Orthopaedic surgeons, like all physicians, must continue to view the patient as a whole, not as a collection of isolated systems. This shift in perspective will not only improve diagnostic accuracy but also restore balance between modern technology and the timeless art of medicine.

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