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

Pradeep Kumar Pathak[1], Priti Ranjan Sinha[1], Pranjal Agrawal[1], Nikhil Gupta[1], Siddharth Jain[1]

Dear Sir,

We sincerely thank the author of the letter titled "Rediscovering the Art of Clinical Examination in the Era of Super-Specialisation" for their thoughtful observations on our case report. We welcome the opportunity to clarify certain aspects of our clinical reasoning and management.

1. Systemic and clinical evaluation

A comprehensive relevant history was taken, and a general and systemic examination was performed, which included the musculoskeletal, cardiovascular and respiratory systems. The findings were not consistent with Rheumatoid arthritis. For conciseness, these were not elaborated in the final manuscript. Our statement that the patient "had no signs or symptoms suggestive of rheumatoid arthritis" was intended to indicate the absence of both articular and extra-articular features.

2. Rationale for surgical intervention

The patient presented with progressive wrist pain and swelling for two months, with ultrasonographic evidence of flexor tenosynovitis and median nerve compression in the carpal tunnel. Seeing the space-occupying lesion in the carpal tunnel along with the weakness of the flexor tendons, timely surgical decompression and synovectomy were indicated on both diagnostic and therapeutic grounds.

Because Disease-Modifying Anti-Rheumatic Drugs (DMARDs) often require 6–12 weeks to achieve clinical efficacy, their initiation in the setting of acute compressive neuropathy would not have addressed the immediate neurological risk [1,2]. Early surgical intervention in such cases prevents irreversible nerve damage [3].

3. Extra-articular manifestations and seronegativity

The possibility of systemic or extra-articular manifestations was clinically excluded. Evidence shows that extra-articular manifestations correlate strongly with seropositivity and disease duration [4,5]. Turesson et al. reported that patients with positive rheumatoid factor or longer disease duration had a markedly higher risk of systemic involvement, including nodular, pulmonary, and vasculitic features [6]. This evidence suggests that in a patient with a brief disease course and a seronegative profile, the likelihood of such manifestations at presentation is extremely low.

In this case, the rheumatoid factor and anti-CCP antibodies were negative. The duration of the disease was only two months. There was no polyarticular involvement. There were no type B

Access this article online

Website: www.jocr.co.in

DOI: https://doi.org/10.13107/jocr.2025.v15.i11.6430

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Dr. Pradeep Kumar Pathak


Dr. Priti Ranjan Sinha


Dr. Pranjal Agrawal


Dr. Nikhil Gupta


Dr. Siddharth Jain

[1]Department of Orthopaedics, Teerthanker Mahaveer Medical College and Research Centre, Moradabad, Uttar Pradesh, India.

Address of Correspondence:
Dr. Pradeep Kumar Pathak,
International Training Fellow, Department of Orthopaedics, Wrightington, Wigan and Leigh NHS Trust, Wigan, Greater Manchester, United Kingdom.
E-mail: dr.pathak09@gmail.com

Submitted: 10/09/2025; Review: 30/10/2025; Accepted: October 2025; Published: November 2025

DOI: https://doi.org/10.13107/jocr.2025.v15.i11.6430

symptoms. The EULAR score was less than six. Hence, exhaustive systemic investigations were not indicated beyond standard clinical screening, which was normal.

4. Delays in diagnosis due to negative RA factor and anti-CCP antibodies

It's well known and widely documented in the literature that the diagnostic process for seronegative cases can be prolonged, often taking several months or even years, as opposed to the more straightforward diagnosis of seropositive rheumatoid arthritis [1,7]. In diagnosing seronegative rheumatoid arthritis, clinicians often face significant challenges due to the absence of definitive serological markers such as rheumatoid factor (RF) and anti-cyclic citrullinated peptide (CCP) antibodies.

4. Diagnostic reasoning and clinical judgement

The surgical decision was driven by both diagnostic uncertainty and therapeutic necessity.

The differential diagnosis included tuberculosis, giant-cell tumour of the tendon sheath, and inflammatory tenosynovitis. Thus, open exploration served a dual purpose:

1. Diagnostic: Excision biopsy to obtain representative tissue samples for histopathology; and

2. Therapeutic: To relieve nerve compression.

This approach aligns with recommended Orthopaedic management when imaging and serology are inconclusive but compressive neuropathy is present [3,6].

5. Concluding remarks

We agree with the author's broader emphasis on holistic clinical evaluation. Our case demonstrates that clinical judgement, corroborated by imaging and followed by timely intervention, remains the cornerstone of safe and effective patient care. We have further emphasised in the concluding remarks of the article that a high index of suspicion and a multidisciplinary approach are key in managing such atypical presentations of seronegative RA [8].

Sincerely,

Pathak PK, Sinha PR, Agrawal P, Gupta N, Jain S.

References

1. Smolen JS, Aletaha D, McInnes IB. Rheumatoid arthritis. Lancet. 2016;388(10055):2023–2038.
2. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 ACR Guideline for the Treatment of Rheumatoid Arthritis. Arthritis Rheumatol. 2016;68(1):1–26.
3. Tang JB, Giddins G. Why and how to treat flexor tenosynovitis surgically. J Hand Surg Eur Vol. 2016;41(2):134–143.
4. Pratt AG, Isaacs JD. Seronegative rheumatoid arthritis: pathogenetic and therapeutic aspects. Best Pract Res Clin Rheumatol. 2014;28(5):651–659.
5. Das S, Padhan P. An Overview of the Extra-Articular Involvement in Rheumatoid Arthritis and Its Management. J Pharmacol Pharmacother. 2017;8(3):81–86.
6. Turesson C, O'Fallon WM, Crowson CS, Gabriel SE, Matteson EL. Extra-articular disease manifestations in rheumatoid arthritis: incidence trends and risk factors over 46 years. Ann Rheum Dis. 2003;62(8):722–727.
7. Coffey CM, Crowson CS, Myasoedova E, Matteson EL, Davis JM 3rd. Evidence of Diagnostic and Treatment Delay in Seronegative Rheumatoid Arthritis: Missing the Window of Opportunity. Mayo Clin Proc. 2019 Nov;94(11):2241-2248. doi: 10.1016/j.mayocp.2019.05.023. Epub 2019 Oct 13. PMID: 31619364; PMCID: PMC6947665.
8. Pathak PK, Sinha PR, Agrawal P, Gupta N, Jain S. Isolated Flexor Tenosynovitis as the Sole Manifestation of Rheumatoid Arthritis: A Case Report. J Orthop Case Rep. 2025 Jul;15(7):211-215. doi: 10.13107/jocr.2025.v15.i07.5828. PMID: 40635947; PMCID: PMC12237482.

Conflict of Interest: Nil
Source of Support: Nil

Consent: The authors confirm that informed consent was obtained from the patient for publication of this article

How to Cite this Article

Pathak PK, Sinha PR, Agrawal P, Gupta N, Jain S. Response to Letter to the Editor: Rediscovering the Art of Clinical Examination in the Era of Super-Specialisation. Journal of Orthopaedic Case Reports 2025 November;15(11):448-449.