From the Editor

Nerve Entrapments in Musicians: Frequent, Yes; Routine, Never

This issue of *Medical Problems of Performing Artists* marks the halfway point of its eighth year of publication, a fact that testifies both to the rapid passage of time and to the growing stability of performing arts medicine. Like several previous special issues, this issue is devoted to a single topic to permit more detailed coverage. The current issue highlights nerve entrapments, conditions frequently encountered in instrumental musicians. The discussion concentrates on the entrapments most frequently seen in musicians, i.e., of the median nerve in the carpal tunnel (carpal tunnel syndrome, CTS) and of the ulnar nerve at the elbow in the cubital tunnel. For the sake of completeness, other nerve compressions, although encountered rarely, are discussed in less depth.

Patients with symptoms suggestive of entrapment syndromes (especially CTS) are so common that to many practitioners diagnosis and treatment are routine. To such practitioners the information presented here may seem superfluous. It is my conviction, however, that as good a case can be made for scrutinizing the routine and commonplace as for dwelling on the bizarre and uncommon, especially in dealing with the skilled arms and hands of musicians.

In evaluating patients with symptoms compatible with but not diagnostic of CTS, practitioners may have a tendency to jump the gun not only on diagnosis, but also on preferred modes of treatment. In other words, there is a danger of assuming that all musicians with wrist pain or paresthesias have CTS simply because they are musicians. Diagnostic studies, clinical follow-up, and willingness to entertain a range of therapeutic possibilities are essential in dealing with musicians.

Although most clinicians may feel competent in the diagnosis at least of CTS, ulnar and median nerve entrapments should be reviewed from the perspective of an experienced neurologist and practitioner in performing arts medicine. Although a few physicians have detailed knowledge of electrodiagnostic tests, most have only a superficial understanding of the procedures involved and of the data derived from electromyograms (EMGs) and studies of nerve conduction velocity (NCVs). Given the importance of such information on diagnosis, treatment, and follow-up, it is necessary to demystify electrodiagnostic testing and to put its use in proper perspective. The author of the article in this issue is an established expert as well as active teacher in clinical electromyography.

The intent of inviting two well-known authorities to discuss surgical treatment of nerve entrapments was to show both similarities and differences in how two surgeons, both experienced in caring for musicians, evaluate and treat these patients. The differences are not earth-shaking, but careful reading of the two articles reveals subtle differences in approach.

Any condition affecting the upper extremities provokes understandable anxiety in musicians, in part because the possibility of surgery looms especially large. No matter how expert, experienced, and self-confident the surgeon may be, sufficient time must be spent with the patient for detailed discussions; simple reassurance is not enough.

Finally, evaluation and treatment of nerve entrapments are discussed in detail, with equal consideration of medical and surgical treatment. This discussion, written by a hand therapist with six years of experience in treating musicians for entrapments and other medical problems, illustrates techniques that are familiar to most physicians.

This issue is not intended to provide definitive discussions of nerve entrapments in musicians. Given that the conditions are common and enter even more frequently into the differential diagnosis, we need occasionally to rethink how best to assess, treat, and rehabilitate patients presenting with these syndromes. As always, we need to encourage skills and techniques that may prevent such problems. The examination of nerve entrapments in this issue stresses primarily the need to avoid the pitfalls of viewing diagnoses or treatments as routine. In most situations viable alternatives exist. Most importantly, no patient is routine. Each must be assessed with an open mind, and the treatment selected must be that which is most likely to serve the patient's long-term needs.

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