From the Editor

Special Treatment for Musicians? Some Specific Hazards of Elective Surgery

As physicians are well aware, therapeutic results are not always predictable. There are too many factors contributing to this to discuss all of them in one brief editorial. However, I would like to share some possible explanations for treatment failures in musicians and more specifically of elective surgery failures in these patients. The objective is not to question medical competence but to consider the application of special criteria that might improve the results of surgery in musicians. All too frequently I find myself serving as a postoperative sounding board for distressed patients and physicians. Both are disheartened, and usually angry, that an elective surgical procedure designed to resolve a painful problem has either failed or left unanticipated new problems in its wake, or both.

The most frequent occupational medical complaint that sends musicians to a doctor is pain, characteristically involving the upper extremities. In most instances this pain appears to stem from acute or chronic overuse as well as misuse of hands, arms, and other body parts integral to playing an instrument. As anyone who has examined musicians will agree, the symptoms with which they present are typically accompanied by a paucity of objective physical findings, and diagnostic studies are more helpful by excluding diagnoses than by establishing them. Thus, the etiologies of the pain syndromes of musicians are frequently difficult if not impossible to pigeonhole diagnostically.

In my experience, musicians with musculoskeletal pain syndromes fall into two general groups. (This discussion does not include the treatment of acute trauma in musicians, which calls for separate consideration.) They come with either (1) a painful problem of recent onset, i.e., within the past 2–3 weeks or (2) problems that are more chronic, having existed for weeks, months, or even years. Indeed the problem(s) with which they later present may bear little resemblance to the initial complaint. It is these patients with chronic complaints in whom elective surgery appears to be most often undertaken, frequently as a kind of last resort on the part of both the patient and the physician. This in itself potentially represents a tremendous hazard by setting up unrealistic expectations that will predictably end in disappointment. We will concentrate on this chronically symptomatic group.

However, first let us briefly consider those musicians with recent onset of their medical problem. It is often possible to trace the onset of the presenting symptom to a single musical event, which occurred in a clear temporal relationship to the pain. Such events include a demanding series of concerts, recording sessions, tours, a faulty instrument, tackling a new repertoire, and preparation for an audition, jury, or recital. In the majority of these patients, noninvasive treatment dictated by common sense, including rest, ice, heat, physical therapy, occupational therapy, nonsteroidal anti-inflammatory drugs, and a large dose of patient education, are the appropriate first-line therapies. Although there may be indications to screen musicians for serious underlying problems, few, if any, should be treated primarily by surgery, regardless of the diagnosis.

Not all medical treatment is successful in any group of patients, and the treatment of musician patients is arguably a special therapeutic challenge. Whether or not they have sought previous medical intervention, ultimately some of the patients from the "acute" group will blend into the "chronic" group, and, as in any cohort of patients with chronic problems, successful treatment can be notably elusive. In taking a history from these "chronic" patients, one will frequently note several things. One is that whatever the nature of the original complaint, the current complaint(s) are apt to be different. The pain may have a different or inconsistent quality, the site may have changed or have multiple loci, and the entire picture is generally more confused and confusing to both patient and physician than was the original problem. Many, if not most, of these patients will have already consulted a large variety of both medical and, oftentimes, alternative practitioners and have been subjected to a variety of diagnostic procedures, some very sophisticated, costly, and frequently inconclusive. These multiple and heterogeneous consultations are the source of much confusion to the patient, with the resultant conflicting diagnoses and contradictory recommendations for treatments.

Not surprisingly, and especially with the passage of time, because of the ongoing disability and the inevitably progressive uncertainty about their occupational future, many musician patients become significantly anxious and depressed. They also become frustrated, confused, demanding, and angry. Their anger is often unfocused, but they are equally angry at the medical and the musical professions. A pain that originally appeared to be only a temporary inconvenience has evolved, by necessity and sometimes with unwitting medical collusion, into the centerpiece of their lives.

Do not misunderstand me. I appreciate and sympathize with what these patients must endure. I am simply searching for ways to meet their medical needs appropriately and promptly, as well as yield the best long-term results, i.e., return them to a functional state. In the course of their ongoing problems, these musicians have had lots

of time to think as well as to get confused. Any treatment undertaken under these circumstances, be it medical or surgical, is especially risky. Therefore, irreversible treatments, such as elective surgery, present special hazards.

It is in this context that I believe we must consider applying stricter and more enlightened criteria in the selection of musician patients for elective surgery. It is inevitable that there will always be mistakes made in this selection process in addition to treatment failures in the face of even the most stringent patient selection.

My hope is that by reconsidering the issues discussed here, as well as many others that were not, we can improve the prognosis for musicians in pain. My plea is that clinicians take a detailed history from these patients in order to get a feeling for the impact of the presenting symptom and its disabling influence on the patient's *entire* life before entertaining an elective invasive procedure. If ever a second and possibly a third, opinion were indicated, it is with these patients, and preferably from doctors who are knowledgeable about the special circumstances of musicians. If, indeed, surgery is held to be a serious possibility, the risks and benefits of a procedure for these particular patients must be thoroughly explored to protect vulnerable musicians and their surgeons.

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