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Innocuousness of office-based olecranon bursa aspiration

I am writing to respond to Lockman's article "Treating nonseptic olecranon bursitis. A 3-step technique"[1] and readers' responses to this article.[2,3] My own prior bias and subsequent experience as a community family physician for more than 35 years seem to echo that of Drs Rivet[2] and Maxwell.[3] Despite the pleading and nagging of numerous patients with painless sterile olecranon effusions over the years, I have steadfastly resisted doing the obvious and simple thing: drain the effusion. They seem to get easily infected, as I was taught years ago, or at least I seem to see many that have become infected following aspiration by someone else. So I find it intriguing to hear of someone having a different experience from mine; I wonder which difference in technique or selection makes for the difference in outcome.

In the Rapid Responses section of the *Canadian Family Physician* website (**www.cfp.ca**), I did not find any clarification of Dr Maxwell's[3] concern about Lockman's description of the procedure[1]: Was the instruction in step 2[1] to inject the steroid and lidocaine mixture into the elbow joint a typographical error (ie, it was actually intended to state "into the collapsed bursal sac") or was this the correct intent? If so, what is the postulated mechanism of the beneficial outcome, given that the elbow joint and the olecranon bursa are not directly connected?

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