Nonseptic olecranon bursitis management

I read with some concern Lockman's article on the treatment of nonseptic bursitis.[1] Although Smith and colleagues[2] confirmed his results, noting the superiority of intrabursal methylprednisolone acetate over oral naproxen or placebo at 6 months, with faster resolution and less reaccumulation of fluid with the steroid injection, this is not a benign procedure, despite Dr Lockman's remarkably low rate of complications.

I have practised throughout my career as an emergency physician and undoubtedly have a very biased view, insofar as I tend to see the treatment failures and complications in the emergency department, and never see the legions of happy patients who have been successfully treated by their family doctors. However, while I have not kept such impeccable records as Dr Lockman, I would estimate that between two-thirds and three-quarters of all the patients with septic olecranon bursitis I have seen in the emergency department over the years (and they probably number in the hundreds) gave a history of their family doctor having "drained" their olecranon bursitis within the previous 2 days. Indeed, no other joint injection or aspiration appears to me to involve such considerable risk of introducing infection into what was a sterile environment. My own experience is borne out by Söderquist and Hedström,[3] who noted an infection rate of up to 10% following bursal injection of corticosteroids.

Given this, I would suggest that, at an absolute minimum (if the clinician is still bent on performing the procedure), full sterile skin preparation, surgical draping, and aseptic technique is necessary, with potent antiseptics such as povidone, followed by alcohol, in the same manner one would prepare for a lumbar puncture. Swiping the skin with an alcohol swab is wholly inadequate.

I am also somewhat concerned by the description of the procedure, in which the bursa is first drained, followed by injection of steroid and lidocaine "into the elbow joint from a lateral approach."[1] The olecranon bursa is extra-articular; it does not communicate with the elbow joint. It is unclear from the description as to whether the injection is being made into the bursa (in which case the best approach is probably parallel to the forearm bones), or rather is truly being made into the elbow joint itself, in which case the lateral approach is entirely appropriate, but the mechanism of the anticipated benefit is less clear.

The usual case of *barfly elbow* (or *student's elbow*), presumably occasioned by the repeated minor trauma of resting the elbows on a hard surface, is entirely benign and will eventually resolve on its own if the patient stops the precipitating activity. Given the lack of adverse consequences associated with "benign neglect," and the clear risk of substantial harm consequent upon breaching the sterile environment, my own bias is towards *primum non nocere.*

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References

1. Lockman L. Treating nonseptic olecranon bursitis. A 3-step technique. *Can Fam Physician* 2010;56:1157.
2. Smith DL, McAfee JH, Lucas LM, Kumar KL, Romney DM. Treatment of nonseptic olecranon bursitis. A controlled, blinded prospective trial. *Arch Intern Med* 1989;149:2527-30.
3. Söderquist B, Hedström SA. Predisposing factors, bacteriology and antibiotic therapy in 35 cases of septic bursitis. *Scand J Infect Dis* 1986;18(4):305-11.

Developmental disability application

I found the research of Stewart and colleagues on integrating physician services in the home[1] to be interesting and encouraging. There is always more than 1 way (and sometimes a better way) of doing things. We are looking for a better way of caring for our adults with developmental disabilities, especially the ones who have difficulty transitioning to adult care because of the complexity of their health issues.

I was very encouraged by the program that the authors were able to develop. The outstanding features were the interest shown by the family doctors in the community, the support offered by the specialist, and the funding obtained for the nurse practitioner and medical coordinator. These are all challenges we are currently facing. I would be interested if the authors or others with similar successes have any practical advice on how such challenges can be tackled.

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Reference

1. Stewart M, Sangster JF, Ryan BL, Hoch JS, Cohen I, McWilliam CL, et al. Integrating Physician Services in the Home. Evaluation of an innovative program. *Can Fam Physician* 2010;56:1166-74.