

Letters to the Editor

Musicians' return to playing instruments following hand surgery

I read with interest the article in the September issue by Butler and Winspur¹ about musicians' return to playing their instruments following hand surgery, but was left wondering whether the researchers came across any variant anatomy contributing to the disorders. Variant anatomy recognized during surgery provides a framework for reviewing common morphology, embryogenesis, and potential medical and surgical implications to reinforce the concept of patient individuality for the individualization of medical and surgical therapies.²

An example of these variations, normal rather than abnormal, is the incidence of separate osseofibrous compartments for the two main tendons (EPB and APL) or for their accessory tendons in de Quervain's disease.³ Decompression of the main fibro-osseous canal may not relieve the symptoms of the disease if an accessory tendon remains unrecognized and is left compressed in its own fibrous canal.⁴ Likewise an accurate injection into both the EPB and APL tendon sheaths by the two-point injection method may be more effective for de Quervain's disease rather than the techniques that do not take the anatomical variation into consideration.⁵

I would be interested in knowing if they came across any variants and if not, I suggest that future research documents such findings for teaching a very important concept in anatomy that may affect function, as in musicians' hands.

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Authors' reply

Mr Ndiyamba highlights anatomical variation as a cause of hand and wrist pain in musicians. This, of course, has been a well-recognized phenomenon in musicians over the years and there is extensive literature on many of the variations. This literature is well summarized by Professor Allieu *et al.*¹ Further comments regarding anatomical variations in musicians are made by Butler and Norris.²

Mr Ndiyamba also comments on separate compartments within the first extensor compartment and the relationship of such compartments to the development and treatment of de Quervain's tenovaginitis. The presence of such compartments is found in 40% of random dissections and the clinical experience of most surgeons matches this.³ There seems to be no correlation between the presence of such compartments and the development of clinical symptoms and this is well explained by the fact that the pathology in de Quervain's disease seems to lie principally in the tendon sheath, where myxoid degeneration is the most striking finding and tendonitis appears to be secondary.⁴ Of the two surgical releases performed in our series, one had an extra compartment. The importance of the extra compartment is seen in treatment. Failure to release such a compartment surgically is a recognized cause of persisting symptoms following surgical release.⁵ Failure to alleviate symptoms with a steroid injection may be due to an extra compartment, which may not have been penetrated and may require a repeat injection.³

Mr Ndiyamba is correct that all treating personnel and surgeons should be aware of anatomical variations and their implications not only in musicians and should document when such variations are shown to exist.

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