

Orthopaedic Case Notes



Unlike in other fields of medicine, the following facts have to be borne in mind while taking patient's history:

- Age of the patient
- Occupation of the patient
- Dexterity
- Disability
- Ambulatory status of the patient (in lower limb/spinal pathology)

In orthopaedics, the treatment option depends on the above factors and the decision-making is crucial which varies from case to case basis. For appendicitis, appendectomy or for tonsillitis, tonsillectomy is the easy and standard solution, irrespective of the profession of the patient. But for correction of a deformity or treatment of a fracture, the choices are many. The treating surgeon should be aware of all the possible options in treating his patient and select the best line with specific advantages and benefits. No similar case may be treated in a similar fashion. The choice of treatment depends on several factors like patient's age, clinical stage or radiological findings, quality of bone, patient's socioeconomic status and many others.

Detailed treatment history for the present ailment should be noted down. Significant major medical problems or hospitalization should be recorded. In children, a detail of the birth history along with developmental milestones is very important. Socioeconomic status and living atmosphere play significant

role in the etiology and treatment of many orthopaedic disorders.

The common symptoms in orthopaedics are:

- Pain
- Swelling
- Deformity
- Stiffness of a joint
- Loss of function
- Disability
- Limb length discrepancy
- Weakness of limb(s) or part of a limb
- Numbness or coldness of a limb
- Sinus/wound/ulcer
- Constitutional symptoms

History of present illness should elaborate on the type of onset of the ailment, its duration, nature, aggravating and relieving factors, and so on. Chronological order of the onset of symptoms has to be followed. Details of the treatment history need to be noted. Significant family history and major medical illnesses or hospitalizations in the past are of great significance. Various personal habits might contribute to the etiopathogenesis of a given orthopaedic disease.

It is a good idea to write down a diagnosis or set of differential diagnosis at this level before proceeding to examination of the patient.

General examination of the patient should revolve around the underlying orthopaedic



Fig. 1.1: An abdominal scar or a scar over iliac crest may give some clue to the surgical procedure undertaken in the past

pathology (e.g. lungs for primary focus of TB; primary tumours in case of bony secondaries; hypermobile joints in recurrent dislocation of a joint, etc.).

Though it is essential to examine the patient from head-to-toe, if there are no significant findings, it may be summarized in 4–5 sentences as follows:

“On general examination, patient is conscious and co-operative. He is averagely built and well nourished. He has no pallor or generalized lymphadenopathy. His vital signs are stable. There are no significant systemic abnormalities detected”.

Local examination in orthopaedics should be systematic:

- Look (inspection)

- Feel (palpation)
- Move (movements)
- Measure (measurements)
- Special tests
- Distal neurovascular status
- Local lymph nodes
- Neighbouring joints

At the end of clinical examination, a provisional diagnosis or a set of differential diagnosis has to be offered with valid reasons.

The diagnosis has to be confirmed before offering treatment. Thus, management of the patient includes investigations, followed by treatment.

The important investigations include: Haemogram, bone profile screening, X-rays,

various types of scans and biopsy of the lesion in some cases.

A given orthopaedic injury or disease may be treated by non-operative (conservative) or operative method. The best method of treatment has to be selected on individual case-to-case basis, with clear-cut indications.

To summarise, following is the method of writing up a case note in orthopaedics:

- Name of the patient
- Age
- Sex
- Occupation
- Chief complaints (in chronological order)
- History of presenting illness (HOPI)
- Past medical history (PMH)
- Family history (FH)
- Social (personal) history (SH)
- Diagnosis at history level
- General examination
- Local examination:
 - Inspection
 - Palpation
 - Movements (active and passive)
 - Measurements (limb length and muscle bulk)
 - Special tests, if any
 - One joint proximal and one joint distal
 - Distal neurovascular status
- Clinical diagnosis/differential diagnosis
- Investigations ordered and their results
- Management planned
- Treatment offered
- Progress in hospital, including complications
- End-result

Orthopaedic surgery includes study of injuries and diseases of the musculoskeletal system.

The injuries include those of bones (fractures), joints (dislocations) and soft tissues like nerves, muscles, tendons, vessels, capsule, synovium, bursae and others.

Orthopaedic disorders may be classified into the following (Table 1.1): Congenital (hereditary or non-hereditary), or acquired:

- Traumatic
- Developmental
- Metabolic
- Inflammatory
- Infective
- Neoplastic
- Degenerative

Table 1.1: Classification of orthopaedic disorders

<i>Condition</i>	<i>Examples</i>
Congenital	Developmental dysplasia of the hip (DDH) Congenital talipes equinovarus (CTEV) Spina bifida
Traumatic	Fractures, dislocations, tendon/nerve injury, sprains and strains
Developmental	Spondylolysis, bone dysplasias
Metabolic	Rickets, osteomalacia, Paget's disease, osteoporosis
Inflammatory	Various arthritides (rheumatoid, gouty, sero-negative arthritis)
Infective	Osteomyelitis, pyogenic arthritis, tuberculous arthritis
Neoplastic	Various soft tissue sarcomas and bone tumours (benign and malignant)
Degenerative	Osteoarthritis, cervical and lumbar spondylosis