

Elbow Pain Scenario:

A 33-year-old male golfer has come in to an outpatient clinic with right elbow pain.

Using the Epi-logical approach, what should be the probable diagnoses?

The clinician should consider all differentials on the clinical mind map. Although the patient is a golfer, the clinician should not anchor at golfer’s elbow, and should continue with the evaluation because the patient’s work, lifestyle, or any recent event can place him at risk for alternate diagnoses.

How should a clinician address urgent/emergent situations?

The patient has normal vital signs, and he does not appear to be in distress.

According to the clinical mind map, there are no urgent/emergent situations. However, the clinician should still review the patient’s vital signs and appearance. Often patients have multiple complaints even when only one is listed as a chief complaint. Sometimes, the chief complaint turns out to be different from what was initially reportedly.

Weighing and Removing Anchor Bias

By asking a few questions, the clinician can arrive at the diagnosis fairly quickly.

The Clinician’s Questions	The Patient’s Responses	How does this information help with diagnostic reasoning?
When did the pain start?	This has been going on for about 2 weeks.	Medial and lateral epicondylitis and olecranon bursitis are more likely, and injury/trauma related conditions, such as a fracture, is less likely
Where exactly does it hurt? Can I see? <i>The clinician can gently grab the elbow so that patient can precisely point to the pain location, or the clinician can let the patient point at the pain location. By doing this, the clinician can also look for additional features, such as swelling or signs of trauma.</i>	Right here. The patient points to the tip of the elbow. (Olecranon process) (There is mild swelling)	The likelihood of Olecranon bursitis increases.
Do you remember any fall or injury to this elbow?	Not really.	Trauma and injury related differentials are less likely.
At this point, the likelihood of Olecranon bursitis is strong, but the clinician must not anchor at this diagnosis. The clinician can ask a few additional questions to rule out any unlikely or rare conditions.		
What kind of work do you do? Do you do any activity with your right elbow, such as weight-lifting, that might have caused an injury?	I work as a painter, and I also lift weights, but I don’t think I pushed myself past my limits.	There is a small possibility of a fracture, but still olecranon bursitis is more likely.

Do you have any weakness in the forearm muscles? Do you feel any numbness in your arm or hand?	I haven't been able to lift weights, but I don't feel any weakness doing daily chores.	Olecranon bursitis is likely.
How often do you play golf?	I haven't played in the last 2 months.	This information decreases the likelihood of golfer's elbow.
The clinician can proceed with a physical exam. By now, the clinician already should have done an inspection, and because this is such a simple scenario, most clinicians can perform a history and a physical exam simultaneously without the risk of getting distracted.		
Elbow exam.	There is swelling and some redness, along with mild tenderness at the olecranon bursa. There is no tenderness at the medial or lateral epicondyle. The patient's range of motion is mildly restricted due to pain. The strength and sensory exam are normal.	Olecranon bursitis is most likely.

In most cases, joint arthrocentesis serves as a diagnostic as well as therapeutic procedure. Olecranon bursitis is a clinical diagnosis, and typically does not require any labs or imaging unless there is a suspicion for an underlying fracture, infection, or a more serious pathology.