Response to the article: “Public Insurance and Single-Guardian Households Are Associated with Diagnostic Delay in Slipped Capital Femoral Epiphysis”

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I have read with a lot of interest the article by Smith et al, entitled “Public Insurance and Single-Guardian Households Are Associated with Diagnostic Delay in Slipped Capital Femoral Epiphysis” (1). The authors aimed to evaluate how socio-economic related patient features, including medical insurance, family structure and the social vulnerability index were associated with a delay in diagnosis (DID) of slipped capital femoral epiphysis (SCFE). I congratulate the authors on this extremely important project. In the path of improving the equity and accessibility of various populations to medical care, providing evidence for the consequences of the lack of equality is particularly valuable.

Interestingly, in their analysis, the researchers also found that longer delays were associated with the physician specialty being an orthopedic surgeon (OS) at the time of presentation. The authors proposed that possible longer waiting times for an OS, and a referral network that mandated a time-consuming referral pipeline before seeing an OS, might have been the reason for this association. They concluded that more attention must be focused on orthopaedic education in the field of primary care. Green et al (2) also studied the DID of SCFE and found a mean delay of 2.5 months and a 52% incidence of apparent missed diagnosis. Their conclusion was very similar to that of Smith et al (1). Of note, the later (1) stated that the association between OS and a DID was surprising. This surprise is understandable, having Hosseinzadeh et al (3) presented that while the SCFE average time to diagnosis was 94±160 days for non-OS physicians, it was found to be only 3±17 days for OS (P<0.00). Their findings support Smith et al reasoning for the association between OS and DID.

The discussion about the questionable association between OS and a DID reminded me of a study entitled “Delay in Diagnosis of Primary Intradural Spinal Cord Tumors” (4). In this study we discovered an association between the involvement of OS in the diagnostic process, and a DID of these tumors. This study was conducted in a country with a strong public medical system, where every citizen had public medical insurance, and the accessibility to OS was high. Although not a qualitative study, I did speak with many dozens of patients and family members as part of the data accumulation. The common theme presented by them was that being evaluated by an OS was considered to be a final reassurance, both by them and by their primary care physician (PCP). In other words, the OS was considered by them as the final ruler regarding their symptoms, and if wrongly diagnosed, it could take a while before this diagnosis was challenged. Having this study presented in a neurosurgery conference, it was us, the OS who have been found by the audience to require a deepening of our knowledge in managing back pain.

As an OS, my lesson from that study was that of humility and responsibility. Our patients often regard us as the “final stop” of the diagnostic process, and when wrongly diagnosed, there might not be a nearby checkpoint ahead. The outstanding article by Smith et al (1) had reminded me of that educational point and made me wonder whether the OS part in the DID of SCFE, or in that matter any other musculoskeletal disease, was indeed “surprising” or was it a role
that we should be constantly aware of and aim to avoid when making diagnosis.

My note on this byproduct of the current study should not take the focus though from the main theme of the study by Smith et al, which importance cannot be over-emphasized.

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References


Conflict of Interest: None Declared