



# Bone and Joint Problems in Children: The Pediatrician on the Front Line: Part 2

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In this issue of *Pediatric Annals*, we present the second part of a special two-part issue on orthopedic concerns that typically present to the pediatrician's office. As I reviewed the nine articles in these two issues, I was struck by the diversity of these problems, yet all of them are often brought to the pediatrician first and not to the orthopedic surgeon or emergency department. There is no question that the pediatrician, as "first responder" to these issues, has a difficult task in sorting out the benign condition from the serious problem. We hope that the clinical scenarios identified in the articles here help in that process.

The first two articles deal with problems related to infection. First, Dr. Noelle S.B. Whyte and I, in the article "Acute Hematogenous Osteomyelitis in Children," describe an increasingly common problem—osteomyelitis secondary to a methicillin-resistant *Staphylococcus aureus* (MRSA) infection. MRSA bone and joint infections continue to rise across the United States. These infections are extremely aggressive and difficult to treat; subsequently, patients have more need for surgical

intervention, more recurrent complications, and often need extended intensive care unit stays.<sup>1,2</sup> Yet, as we highlight in the article, the infection may take several days to intensify, not peaking until the patient presents with sepsis and then quickly becoming critically ill. In the second article on infections, Dr. Deirdre D. Ryan, in her article "Differentiating Transient Synovitis of the Hip from More Urgent Conditions," discusses an illustrative case of a child who is ultimately found to have transient synovitis of the hip. Making the distinction between septic arthritis of the hip, a true emergency, and toxic synovitis, a generally benign inflammatory condition, can be difficult. Dr. Ryan gives an excellent review of the examination steps and diagnostic tools used for these two different conditions that can present with almost identical symptoms. She defines the Kocher criteria, an important algorithm in differentiating between these two conditions.

In the next article, "Elbow Pain After a Fall: Nursemaid's Elbow or Fracture?," Dr. Anna Cohen-Rosenblum and I describe acute onset of elbow pain after a fall. It is likely that most

pediatricians have taken care of many children with nursemaid's elbow. But the primary care physician has to be cautious about trying to figure out the mechanism of injury. A common mistake is to think that elbow pain without an obvious fracture is always a nursemaid's elbow. We review the clinical and radiographic clues that can distinguish between an occult fracture, which requires immobilization, and a nursemaid's elbow, which improves quickly with a reduction maneuver.

Finally, Drs. Ananth S. Eleswarapu, Bakhtiar Yamini, and I, in the article "Evaluating the Cavus Foot," describe the condition, the underlying causes, its common presentation, and diagnostic methods. The primary care physician must be aware that the high-arched foot—the cavus foot—is quite different from the flat foot. The majority of flat feet have a benign etiology; however, cavus feet are often a result of a serious core neuromuscular condition, such as Charcot-Marie-Tooth disease or spinal cord pathology.

I would like to thank all of the contributors for their hard work, and we hope that the readers will find the articles interesting and educational.

**REFERENCES**

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**About the Guest Editor**

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