



## OOS or MUD: unclear thinking is the problem

In his recent letter to the NZMJ (<http://www.nzma.org.nz/journal/116-1181/594/>),<sup>1</sup> Dr Wigley endorses one theme of my paper (<http://www.nzma.org.nz/journal/116-1176/480/>):<sup>2</sup> that there is an oversupply of acronyms. Though entertaining, his letter gilds the lily and avoids the most crucial issue. Unclear thinking is the basic problem.

Acronyms are only a symptom. Amusing ones are easy, but memorable acronyms based on meaningful terminology are a way to address this basic problem. A recent paper provides an excellent example. Responding to reports about deep vein thrombosis and various environments (such as airliners), the authors discard terms such as ‘economy class syndrome’ and offer the witty and instructive acronym, SIT: seated immobility thromboembolism.<sup>3</sup> Similarly constructive thinking might eliminate ‘OOS’ – a term with no further value.

OOS was perhaps conceived as an umbrella term, representing 20–30 possible diagnoses. Now the situation is more obscure, because OOS is used by some as a kind of Swiss Army knife, simulating a clinical diagnosis in a single case instead of being a collective name. This is not just a layperson’s slip of the tongue. Numerous doctors use OOS as a diagnosis, even in court evidence.<sup>4</sup> They imply a single diagnosis such as regional pain syndrome or non-specific arm pain and say the symptoms and signs are ‘typical’, while not admitting to this non-standard usage of OOS. Misusing a collective name in this way brings the medical profession into disrepute, and is fatal to the more general (and misconceived) meaning.

Dr Wigley now suggests dumping all acronyms. This is an over-reaction, with an illusion of simplicity; an erased blackboard is simple only in conveying no information at all. In such a confused field, as some acronyms die out others are created (such as DES, desk edge syndrome, and KROOS, keyboard-related OOS). There is negligible value in such diffuse and ambiguous neologisms, which cement into a ‘simple’ clinical diagnosis a cherished theory about possible causes. Unless professionals separate the two decision steps (used case by case), first making a clinical diagnosis and then determining the cause, they risk a serious loss of credibility. We need terms that clarify this two-step decision process.

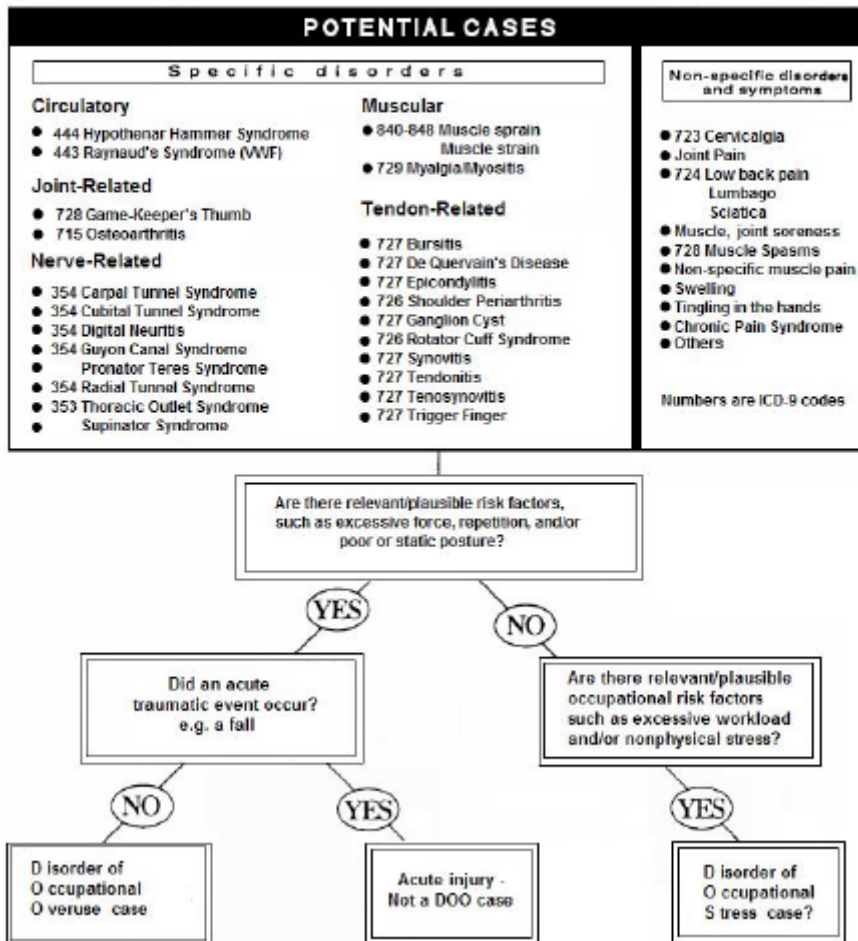
The algorithm below shows the value of two new terms.<sup>5</sup> These are intended to thin, not thicken, the alphabet soup. We can retain the term ‘work-related musculoskeletal disorders’ (WMSDs). This encompasses the largest group of conditions affected by work while not implying a known cause. If good evidence is available, some WMSDs may be subdivided. One involving significant physical work factors would be a disorder of occupational overuse (DOO); one without (but with significant non-physical work factors) would be a disorder of occupational stress (DOS). Self-evidently not specific diagnoses, these are collective names indicating where cases fit in terms of liability under compensation or health and safety law.

In the algorithm, most diagnoses implied by OOS are listed in the boxes labelled ‘Potential cases’. About ten are syndromes in the correct sense of that word. Dr Wigley only adds to the confusion by suggesting that chronic pain syndrome – a

disorder involving non-specific pain and thus belonging in the right-hand box – could be ‘a still wider umbrella under which the OOS umbrella term can shelter’. This implies that all cases of OOS, even those involving specific pain (such as De Quervain’s tenosynovitis), could be CPS.

## Decision pathway for DOO/S... Disorders of Occupational Overuse/Stress

*P Dodwell - modified after Hagberg et al, in "Work-Related Musculoskeletal Disorders"*



Treating the concept of syndromes as though they could be nested in layers like Russian dolls (RD) might seem part of the same tongue-in-cheek approach. However, the OSH/ACC guidelines already use two layers of this flawed approach to syndrome terminology.<sup>6</sup> Unnecessary blurring of boundaries between genuine syndromes is further reason to reject the term ‘OOS’ from serious scientific writing, and I am pleased that vague and misleading terms of this sort were avoided in a recent paper on the subject.<sup>7</sup>

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## References:

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