Public comments	Commentor	Response
My experience is that the medical community at large has had the same “Work place exposure to CTS including activity” guidance for several years. Yes, the medical community at large continues to opine that every keyboarding claim is work related. In my experience, a large number of them come from Occupational Medical Providers who you would think would be educated on the exposure risks and Labor and Industries rules. This adds extra costs either by accepting claims that shouldn’t be accepted or by forcing employers/LNI to obtain additional opinions. If the disconnect between the medical community and the policy continues as is, the definition is useless. There needs to be either greater provider education or stronger policy commitment.	Glenn Hansen	Thank you for the feedback regarding community standards and views. Consistent provider education and decision-making is always challenging. We believe our CTS policies are consistent across both the surgical and conservative recommendations.
1. Under case definition, bullet #3 the phrase “the latter” doesn’t make sense since there is no “former”	Andrew Friedman	Corrected
The “severity” determination is problematic. The document does not outline a grading system for severity but suggests mild CTS or mile to moderate CTS should be managed conservatively but not clear what that means. There is controversy in the emg world about these terms and what they mean from an emg perspective, in fact the AANEM has a project ongoing to decide if there is a system for which to grade severity based on emg findings and there is no agreement and this being said I’m not sure that there is an agreement about this from a more global perspective. This document does define mild as essentially no objective findings (normal nerve conductions, no atrophy etc). I agree that this exists and is real but should treatment be continued with no objective findings?	Andrew Friedman	The definitions of severity found in the literature were inconsistent and not necessarily aligned with objective findings or patient outcomes, or were proposed theories. We clarified the significance of objective, but mild findings that warrant continued conservative care.
. Under work-related summary paragraph: This sentence says “delayed conduction velocity’ which is not corrected. It should be “delayed distal latency” or ‘“SLOWED or REDUCED conduction velocity”—the former is more correct assuming it will be understood by the reader	Andrew Friedman	changed to "slowed or reduced median nerve conduction velocity" for easy understanding in the summary. Distal latency is left in the technical section on pg 17 of electrodiagnostic testing.
Severe sx early on or continued sx for six mo warrants surgical referral…I would think that the indications for surgical referral would include abnormal emg/ncs, abnormal motor findings such as thenar atrophy, ongoing sx interfering with normal activity after a trial of conservative care for 4 weeks (this is how long bracing usually takes to work according to studies I’ve read) or a combination of any of these with abnormal NCS being required for surgical consideration unless the AP does not order the NCS themselves or that is not the intent.	Andrew Friedman	"Severe Symptoms" encompasses what is listed as referral factors. Text was amended to "Severe symptoms with neurological signs" for clarity. The trials for conservative care seem beneficial from 1-3 months, as long as they are able to maintain daily activities, longer than prior recommendations An example:https://pubmed.ncbi.nlm.nih.gov/30015499/
The term “hypalgesia” is used in several places. This means decreased sensitivity to pain which is not the correct term in my opinion. It is actually “numbness, decreased sensation (and most sensitively decreased two point discrimination) or to keep it simple could use the term hypesthesia.	Andrew Friedman	Added "hypesthesia" to pg 3 - "document areas of" and pg 28.
Under table “case definition” just want to confirm that it’s intended under low probability to be written as it is: Keyboard >20 hours per week. Some studies have suggested that intensive keyboarding greater than 20 hours per week is a risk factor and so wanted to make sure we don’t mean keyboarding < 20 hours per week	Andrew Friedman	Yes, low and inconsistent probability associated with keyboard use overall. Consistent with our guidance in surgical guideline.

Under ddx considerations: I'm skeptical that the common bilateral presentation is related to spread of inflammation to the DRG. I didn't read that paper but it sounds implausible to me and the bilaterally is probably most likely related to similar anatomy (e.g small carpal tunnels, obesity, diabetes or other reasons the nerve is sensitive to compression)	Andrew Friedman	Removed the proposed rationale, since it is hypothetical.
Bullet points under ddx you might want to include peripheral neuropathy and B12 deficiency	Andrew Friedman	This suggestion may fit in other categories, but is worth clarifying with an additional bullet. Added "peripheral neuropathy or B12 deficiency"
Thumb abduction test: should be done with the IP joint flexed or it does not test the APB in isolation	Andrew Friedman	Added a note regarding interphalangeal flexion
Square wrist sign is confusing. People with positive NCS frequently have a square wrist but how many people with a square wrist have positive NCS? OK to leave it is I guess..	Andrew Friedman	It appears in the literature with some frequency, although it is not a powerful diagnostic tool.
Return to work timing. Again I didn't read the studies cited here but in our IIMAC subcommittee the hand surgeons felt RTW was appropriate after the skin incision was healed so in general I would encourage earlier RTW post surgery	Andrew Friedman	Added "Clinical recommendations are that RTA is appropriate once the skin incision is healed and early RTW is encouraged."
Under conservative summary—paragraph says if CTS interferes with ability to work for 6-8 weeks consider NCS or surgical referral. I think the CTS guideline suggests time loss greater than 2 weeks should prompt NCS and I'd make this statement moreconsistent with that.	Andrew Friedman	Case defintion states two weeks of timeloss as a criteria for imaging, and in other pages. The intent here was 6-8 weeks of modified duty interference, not full time loss. Added clarification in text.
I'm surprised that work hardening is said to have a high level of benefit. Is this post carpal tunnel release? Increasing activity through work hardening should make most carpal tunnel worse I would think.	Andrew Friedman	In discussion with clinicians doing this work, they agree it is usually responsive and treatment includes managing proper ergonomics, joint positions, modifying job tasks/tools, and learning self-management techniques. Added language to that effect helping to describe the goals and purposes.