

# TENNIS ELBOW

Tennis elbow, also known as lateral epicondylitis, is one of the commonest disorders of the elbow, present in 1% to 3% of people. It is most frequent between 40 and 50 years of age and in the dominant arm. It involves one of a number of extensor muscles (ECRB) that originate together from the humerus bone.

The cause is poorly understood but it is thought to be due to a micro-tear or degeneration of the muscle. Whilst some regard overexertion as a causative factor, there is little evidence that it is commoner among manual workers (or tennis players) or clearly associated with any particular working activity. When it does occur, however, it is likely to be more troublesome in those with manual work.

Tennis elbow causes pain on the outside of the elbow that often radiates to the forearm. The pain is usually aggravated by use of the arm, particularly lifting. Pain occasionally follows an acute traumatic event but the onset is more often insidious and instigated by repetitive extension of the hand and wrist against resistance.

Many treatments have been described either alone or in combination. Most are a waste of time, many are a waste of money (e.g. magnets) and some can be harmful. Steroid injections can result in short-term relief of symptoms but no beneficial effects have been shown in the medium to long-term. The injections are uncomfortable and there is the risk of scarring at the site of injection. Other treatments include anti-inflammatory drugs, physiotherapy techniques, splints and less conventional methods such as radiotherapy, acupuncture and vitamins. Studies have not shown any clear benefit to result from any particular type of treatment.

The natural history of tennis elbow is a slow (12-18 months) resolution of the problem. My approach is therefore very minimalist, as most patients will get better whatever is done. The best approach is to avoid aggravating the problem as much as possible. It is best to just accept that some leisure pursuits have to be put aside until the following year and to concentrate on others that do not hurt the arm. Elbow splints are probably of some use but only to remind you not to do some activities.

Surgery is considered in patients with severe or chronic tennis elbow and little or no response to treatment. This involves release of the common extensor origin through a short incision of the side of the elbow. This does not cause a long-term weakening of the arm once the muscle has healed.

The operation is usually performed under general anaesthetic as a day-case. The elbow will be dressed with a supportive dressing that permits movement and light hand use. Your stitches will be dissolving by about two weeks after your operation. You can drive a car at this time as long as you are comfortable and have regained full finger movements. Timing of your return to work is variable according to your occupation and you should discuss this. Possible complications include:

**Wound** Possible problems include swelling, bruising, bleeding, blood collection under the wound (haematoma), infection and splitting of the wound (dehiscence).

**Scar** You will have a scar on the elbow, which will be firm to touch and tender for some months. This can be helped by firm massage with the moisturizing cream.

**Nerve damage** Nerves running in the region can be bruised or damaged during the surgery and form a painful spot in the scar (neuroma) or numbness down the side of the forearm.

**Function** The symptoms and your function will recover slowly and it will probably be six months before you will get your final result.

**Regional pain syndrome** About 5% (1 in 20) of people are sensitive to hand surgery and their hand may become swollen, painful and stiff after the operation. This problem cannot be predicted, is variable in severity and is principally treated with physiotherapy.

