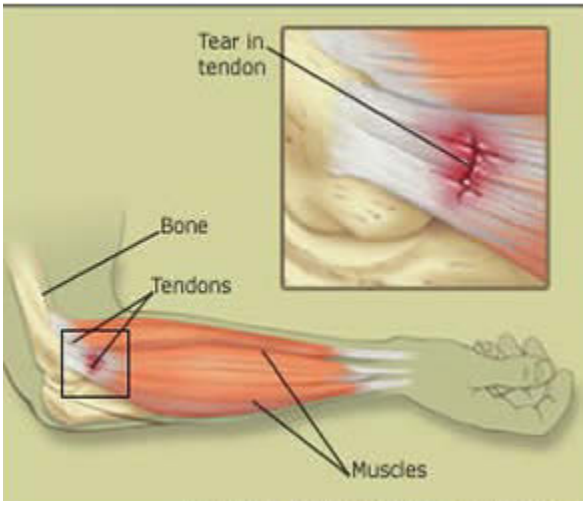
Medial Epicondylitis (Golfer's Elbow)



What is it?

Medial epicondylitis occurs with pain and inflammation on the inside of the elbow where the muscles that flex the wrist attach to the bone. This can occur not only in golfers but in anyone who performs repeated motions of the wrist. (See Figure 1.)

What are the symptoms?

Commonly, this occurs with pain and tenderness on the inside or medial side of the elbow, pain or weakness with gripping or twisting of the wrist, and pain with lifting objects.

What causes this?

Epicondylitis is caused by repetitive stress and strain to the muscles and tendons that attach the forearm muscles to the elbow. This can include any sudden change in activity level or intensity, or any incorrect grip or grip size in racquet sports. This repetitive stress causes microscopic tearing of the tendon. Blood supply to this area is poor and thus commonly the healing response is limited.

What is the treatment?

Nonsurgical treatment is the cornerstone of care for medial epicondylitis. We break our nonsurgical treatment into 2 phases.

Phase 1: Phase 1 has several features, including:

- cessation of offending activities
- ice elbow for 15-20 minutes 3-4 times per day
- oral non-steroidal anti-inflammatory drugs (NSAIDs)
- night splinting
- occupational modalities, including ultrasound treatments



Phase 2: As soon as symptoms are improved by Phase I treatment, we begin a guided rehabilitation program. Establishing full, painless, wrist and elbow range of motion is our first goal, soon followed by stretching and progressive isometric exercises. Initially the elbow should be flexed during these exercises to minimize pain, but as you progress, greater elbow extension should be continuously achieved.

Each stretch should be held for at least 10 seconds, then relax the arm and repeat up to several times a day and in between activities. Minimally 3 sets of 20 repetitions should be performed.

As preinjury flexibility and strength return, concentric and eccentric resistive exercises are added to the Phase II program. The achievement of greater-than-preinjury strength is the ultimate goal, because preinjury muscle strength proved vulnerable to tension overload.

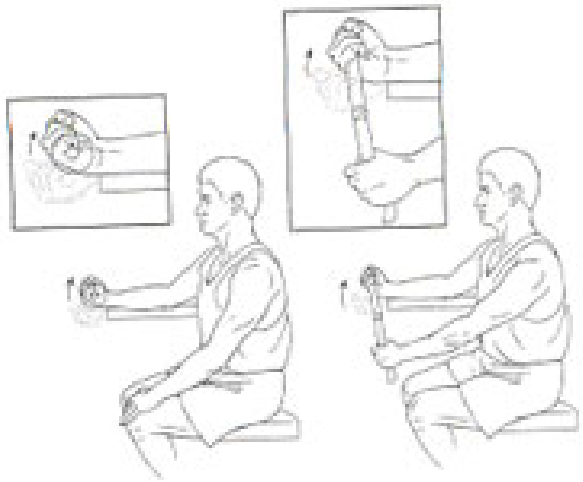


Figure 3: Wrist Flexors

Strengthening exercises will also help. (See Figures 3-4.) While doing any strengthening, exercises should always be pain free and done with a light weight and at least 3 sets of 20 repetitions.



Figure 4: Supination (left) and Pronation (right)

Surgical: If a you fail to respond to a disciplined, 3- to 6-month nonoperative program and all other possible pathologic causes for the pain of epicondylitis have been excluded, surgical treatment is recommended.
Through a small incision over the bony prominence on the inside of the elbow, the base of the diseased tendon is removed and normal tendon tissue is reattached to the bone. This is an outpatient surgery.

Post operative rehabilitation

At 7 to 10 days postoperatively, the splint and skin sutures are removed. At this point, gentle passive and active hand, wrist, and elbow exercises are begun. Gentle isometrics are undertaken at 3 to 4 weeks postoperatively, with more rigorous, resistive exercise, including wrist flexion and forearm pronation, beginning at 6 weeks. A progressive strengthening program follows. Generally, you will normally return to activities by 3 to 6 months postoperatively.

Best wishes,

Andrew Pastor, M.D.