

Elbow Tendinopathy



Michael E. Pitzer, MD, Peter H. Seidenberg, MD*,
Dov A. Bader, MD

KEYWORDS

- Elbow tendinopathy • Tennis elbow • Golfer's elbow • Lateral epicondylitis
- Medial epicondylitis • Elbow overuse injuries

KEY POINTS

- Epicondylitis is thought to be an angiofibroblastic tendinosis and not an inflammatory condition. As such, epicondylitis and tendinosis are more appropriate terms.
- Epicondylitis is a clinical diagnosis and further investigations (radiographs, magnetic resonance images, and nerve conduction tests) are used after a failure of conservative therapy to rule out other clinical entities.
- Most patients improve with time and conservative therapy.
- Corticosteroid injection may reduce pain in the early stages of epicondylitis but has not been shown to be better than placebo for long-term treatment.
- Patients may benefit from a trial of platelet-rich plasma or autologous blood injection prior to consideration of surgical intervention in recalcitrant epicondylitis.

INTRODUCTION

The elbow is a three-joint complex formed by the humerus, radius, and ulna.¹ It allows for flexion and extension of the elbow and flexion, extension, pronation, and supination of the wrist (**Fig. 1, Table 1**). The wrist extensors originate from the lateral epicondyle of the humerus, whereas the flexors originate from the medial epicondyle (**Figs. 2–4, Tables 2 and 3**). Epicondylar pain is a frequent patient complaint. Commonly referred to as tennis elbow and golfer's elbow, respectively, these overuse injuries are related to sport, recreational, and/or occupational activities.

PREVALENCE

The prevalence of medial and lateral epicondylitis is variable depending on the population. In a Finnish study of 4783 persons, the prevalence of lateral epicondylitis was determined to be 1.3% and the prevalence of medial epicondylitis was determined to

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Penn State Sports Medicine, Penn State University, State College, 1850 East Park Avenue, Suite 112, State College, PA 16803, USA

* Corresponding author.

E-mail address: pseidenberg@hmc.psu.edu

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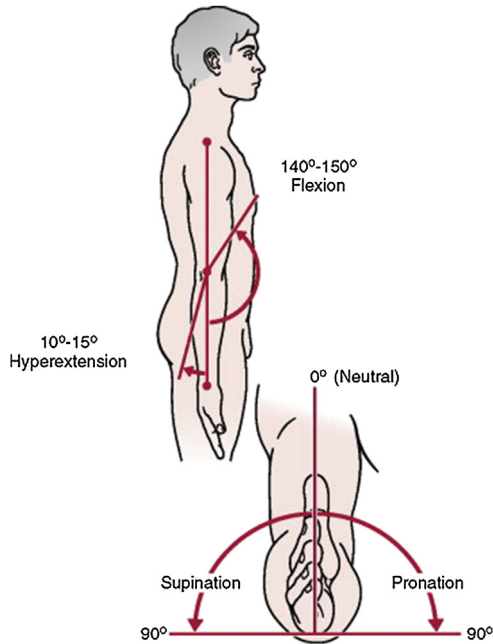


Fig. 1. Elbow range of motion. (From Magee DJ, Sueki D. Orthopedic physical assessment. Philadelphia: Elsevier; 2011; with permission.)

be 0.4%.⁵ In a recent study of the US military, incident rates for lateral and medial epicondylitis were 2.98 and 0.81 per 1000 person-years.⁶ In an occupational health study of 1757 subjects performing repetitive upper extremity movements as part of their occupation, the prevalence of medial epicondylitis was 3.8% (68 of 1757) at the beginning of the study.⁷ Three years later this same study found prevalence in the same population to be 5.2% (31 of 598) and calculated the annual incidence of medial epicondylitis in this occupational population to be 1.5%.⁷ Lateral epicondylitis has long been associated with racquet sports, and an estimated 10% to 50% of tennis players develop lateral epicondylitis over their careers.¹⁵ Although the incidence of lateral epicondylitis is equal in men and women in the general population, male tennis players are more often affected than female players.¹⁶ Medial epicondylitis predominantly occurs in the fourth and fifth decades with rates in males and females nearly equal, affecting the dominant arm in 75% of patients.¹⁷ Overall, lateral epicondylitis is 7 to 10 times more common than medial epicondylitis.⁴

Table 1 Active movements of elbow complex	
Motion	Degrees of Motion
Flexion of elbow	140–150
Extension of elbow	0–10 (hyperextension)
Supination of forearm	90
Pronation of forearm	80–90

From Magee DJ. Elbow. Orthopedic physical assessment. 5th edition. Philadelphia: WB Saunders; 2002. p. 368.

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