Do We Need to Treat Tennis Elbow?

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During a symposium at the recent American Society for Surgery of the Hand Annual Meeting on tennis elbow, a debate ensued regarding the optimal treatment for this troublesome tendinopathy that we all see in our offices. Based on data from the randomized, controlled trial by Smidt et al1 on 185 patients with lateral epicondylitis, patients who were treated expectantly did as well as those treated with a single steroid injection or with therapy. Although myriad studies have been performed retrospectively and prospectively to support or refute splinting, steroid injection, platelet-rich plasma injection, ultrasound, iontophoresis, and various surgical procedures,2-11 the question that these studies have raised is: do we need to do anything?

Although we can all recall the patient who got better after our treatment, it is possible that the patient would have gotten better over time with no treatment. Even more controversial, what if our treatments cause worse long-term outcomes? Bisset et al12 performed a randomized trial comparing 3 treatment modalities in 198 patients with a minimum of 6 weeks of symptoms of lateral epicondylitis: treatment with 1 corticosteroid injection, treatment with 8 sessions of physiotherapy, and a wait-and-see approach. At 1-year follow-up, the therapy and wait-and-see approaches had a 94% and 90% success rate (defined by participants as much improved or completely recovered), respectively, compared with a 68% success rate with injections. Interestingly, the group treated with physiotherapy sought fewer additional treatments compared with the other 2 groups, whereas the patients receiving a steroid injection had high rates of recurrence and had significantly poorer outcomes scores than the other 2 groups at 1 year.

These studies have changed the way I treat patients with epicondylitis. First, I tell them that this problem typically goes away on its own given enough time (up to 1-2 years), and I assure them that they are not causing their elbow damage if they do not have treatment. Second, I discuss all of the options and the evidence for and against the treatments available. Finally, the patient and I decide together what happens next. For some, that is no treatment, but for others, therapy, injections, and splints all play a role. I believe the most important part of this process is education. Knowledge is power, and our patients need to be educated participants in their care. Think about what you would do for your own painful tennis elbow—is it more or less than what you would offer your patients?

REFERENCES


