Rotherham Elbow Pathway Supporting Information

Distal Biceps Tendon Rupture

Patient presents with

- A history of forceful contraction involving the biceps resulting in pain and bruising over the anterior aspect of the forearm
- Localised swelling in the area and if the tendon has retracted a lump may be seen in the upper arm.
- Patient may have a very manual job or lift heavy weights.
- More common in males than females.
- Only management is **urgent referral** to Orthopaedics for consideration of repair.

Tennis Elbow

Patient presents with

- Pain described as a dull ache and / or sharp shooting pain over the lateral epicondyle +/- radiation into the forearm
- Pain on gripping activity or when making a “fist”
- Onset of symptoms after repeated activity involving wrist extension e.g. backhand in tennis, using computer keyboard
- No pins and needles are reported
- Tenderness and pain on palpation of the soft tissue mass over the lateral epicondyle rather than the bony epicondyle.
- Increased pain on resisted wrist and middle finger extension
- Reduced and painful wrist flexion as a result of the stretch on the extensor muscles and their attachment
- Elbow and shoulder ROM are usually unaffected.
- Advice regarding rest and avoidance of aggravating activities, especially palm down lifting. Therefore advise palm up when lifting. Advise to apply ice to the painful area.
- Please exclude cervical origin
- Please exclude radio-capitellar OA with pain on pronation and supination, and pain on compression with pro and supination

Golfer's Elbow

Patient presents with

- Pain described as a dull ache and / or sharp shooting pain over the medial epicondyle +/- radiation into the forearm
- Pain on activities that involve flexing the wrist or gripping
- Onset of symptoms after repeated activity involving wrist flexion e.g. playing golf, using screwdriver
- No pins and needles may be reported in the Ulna Nerve distribution of the hand
- Tenderness and pain on palpation of the soft tissue mass over the medial epicondyle rather than the bony epicondyle.
- Increased pain on resisted wrist flexion and passive extension due to the stretch on the flexor muscles and their attachments
- Elbow and shoulder ROM are usually unaffected.
- Advice regarding relative rest and avoidance of aggravating activities especially palm up lifting. Advise to apply ice to the painful area.
- Please exclude cervical origin and in older patients rule out OA of the elbow with A-P and lateral elbow x-rays

Osteoarthritis

Patient presents with

- Gross pain over the elbow joint with associated swelling primarily at end of range flexion and extension
- Some stiffness in the joint after periods of immobility
- History of strenuous manual work and /or previous trauma to the elbow joint that that disrupted the joint surfaces
- May report locking if osteophytes are present on x-ray
- Clinically reduced Active Range of Movement especially terminal extension
- Crepitus is often felt through range of movement
- Effusion may be present over the lateral aspect of the joint
- Management depends on the patient's ability to cope with symptoms and their effect on their quality of life

Loose Bodies

Patient presents with

- Clicking and locking of the elbow which may be painful
- Possible swelling of the elbow joint
- Common in people who undertake sports or occupations that involve repeated overhead activity or heavy lifting (forced elbow extension)
- May have a block to full extension of the elbow

Ulna Nerve Entrapment at the Cubital Tunnel

Patient presents with

- Pain around the medial epicondyle
- Pins and needles or loss of sensation in the Ulna Nerve distribution of the affected hand (Little finger and ulna border of the ring finger)
- Aggravated by prolonged periods of elbow flexion, or direct pressure over the olecranon e.g. Resting elbows on a desk
- Usually worse throughout the night especially if sleeps with elbows flexed.
- Increased symptoms and tenderness on palpation of the ulna groove at the elbow
- Wasting of the intrinsic muscles of the hand
- Positive Froment's sign and positive passive elbow flexion test.
- In severe cases involuntary abduction of the little finger and clawing of the little and ring fingers may be evident
- Positive Tinel's sign at the elbow
- In the case of subluxing Ulna Nerve you may feel a "pop" or "click" over the ulna groove as the elbow is moved. This will be associated with pain and distal symptoms.
- Please exclude cervical and radicular symptoms (C8 nerve root)

Radial nerve entrapment (posterior interosseous branch)

Patient presents with

- Weakness or paralysis of the wrist and digital extensors.
- Pain may be present, but it usually is not a primary symptom.
- Attempts at active wrist extension often result in weak dorsoradial deviation. These patients do not have a sensory deficit.

Management:

- Conservative treatment for 6-12 weeks: refer to physiotherapy for cock-up splint and activity modification help limit repetitive elbow extension, forearm pronation, and wrist flexion. Anti-inflammatory drugs

- Surgery is indicated if no improvement occurs or paralysis increases.

Elbow instability

Patient presents with

- History of previous elbow dislocation or previous surgery

- Patient feels as though elbow is giving way

- Unable to do press-ups or push up off chair

- Varus +/or valgus stress tests may be positive

Management:

- X-ray elbow AP and lateral

- Refer to orthopaedic surgeon

Olecranon Swelling

Patient presents with

- Swelling over the posterior aspect of the elbow (olecranon)
- This will either be due to a simple bursitis but may need to rule out infection

Management

- Advice on ice, maintain range of movement, analgesia as required
- These do not require onward referral to MSK CATs or Orthopaedics for aspiration as this is no longer considered.
- Only consider onwards referral to Orthopaedic Consultant in the case of recurrent infection.