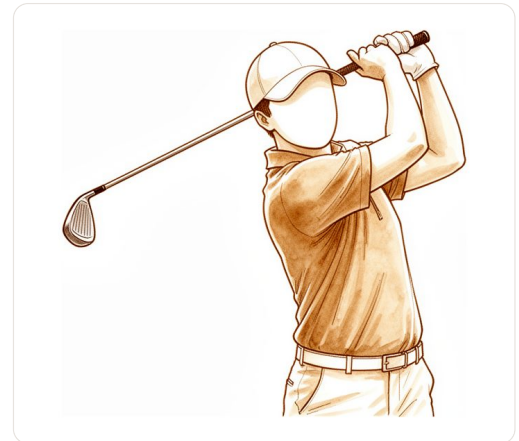


Golfer's Elbow

Golfer's elbow: the tendons that flex your wrist and fingers attach to a bony bump on the inside of your elbow, and overuse causes pain and degeneration where they meet the bone.

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What you're feeling

You are likely experiencing pain on the inner side of your elbow. This is where the tendons that help you bend your wrist and fingers attach to the bone. The discomfort often starts gradually. It may feel like a dull ache that turns sharp when you move your arm in certain ways.

The pain typically worsens when you grip objects or lift things. You might notice it flares up after activities that involve repetitive wrist movements. For example, swinging a golf club, throwing a ball, or even using a screwdriver can trigger symptoms. Lifting a heavy shopping bag or turning a doorknob may also become difficult and painful.

Many patients find that the pain is most noticeable in the morning. You might feel stiffness when you first wake up, which eases slightly as you move around. However, pushing through the pain during daily tasks can make it worse later in the day. Some people report that the ache keeps them awake at night, especially if they sleep on that side.

In some cases, the pain may travel down your forearm towards your wrist or fingers. You might also feel tingling or numbness in your ring and little fingers. This happens because the ulnar nerve runs close to the painful area. If you have had a previous injury to this elbow, you may feel a sense of instability or weakness when trying to lift objects.

It is important to listen to your body. If simple rest does not relieve the pain, or if you notice swelling or bruising, you should seek medical advice. Your surgeon will examine your elbow to determine the exact cause of your symptoms and recommend the most appropriate treatment plan for you.

What's actually happening

Golfer's elbow is a wear-and-tear injury to the tendons on the inside of your elbow. These tendons connect your forearm muscles to the bony bump on the inner side of your elbow, known as the medial epicondyle. Think of

these tendons as thick ropes that help you bend your wrist and turn your palm. When you grip a golf club or perform repetitive motions, these ropes are under constant tension.

Over time, this repeated stress causes tiny tears in the tendon fibres. The body tries to repair these tears, but the process can become overwhelmed. This leads to inflammation and pain at the point where the tendon attaches to the bone. The area becomes tender and weak, making everyday tasks like lifting a cup or turning a doorknob uncomfortable.

Your forearm muscles also play a key role in keeping your elbow stable. They act like a dynamic support system, holding the joint together when you apply force. If these muscles are tight or weak, they may not stabilise the elbow effectively. This can place extra strain on the already irritated tendons, worsening your symptoms.

In some cases, the bony attachment itself may be affected. Small fragments of bone can become loose or fail to heal properly, especially after an injury. This can lead to instability in the joint, causing further pain and limiting your movement. Your surgeon will assess whether the issue is primarily with the soft tissue tendons or if there is a structural change in the bone.

Understanding this mechanism helps explain why rest and targeted rehabilitation are often effective. By reducing the strain on these ropes and strengthening the supporting muscles, you can allow the tissue to heal and restore stability to your elbow.

What we can do about it

Dr Kieran Hirpara, an upper-limb surgeon at Mater Private Hospital Rockhampton, starts with the least invasive options that suit your condition. We begin by helping you manage symptoms through self-care and guided exercise. You will learn to modify activities that strain the inner elbow tendon. Physiotherapy focuses on gentle stretching and strengthening to improve blood flow and reduce pain. We usually recommend giving this non-operative approach at least several weeks to show results. This allows the tendon time to heal and adapt to new movement patterns.

If simple measures do not provide enough relief, we may discuss medical management. This can include pain relief medication or anti-inflammatory drugs to calm the irritation. We may also offer injections to reduce inflammation directly at the source. Cortisone injections can provide short-term pain relief, while other options like hyaluronic acid or platelet-rich plasma (PRP) aim to support tissue healing. The duration of benefit varies for each person, but these treatments are designed to bridge the gap while your body repairs itself. We tailor the choice to your specific pain levels and response to previous treatments.

Surgery is considered only when conservative care has not given enough improvement after a reasonable trial period. We review your progress carefully to ensure that non-surgical options have been fully explored. If symptoms persist and impact your daily life, we may discuss surgical intervention. This typically involves removing damaged tissue or releasing tight structures to relieve pressure on the tendon and nearby nerves. For acute injuries or structural issues, surgery may be recommended sooner. We ensure you understand the potential benefits and risks before making a decision.

Patients are generally referred to our clinic by their GP; if a physiotherapist has suggested you see us, you will still need a referral from your GP in order to be eligible for the Medicare rebate. A clinic assessment, including a detailed history, physical examination, and imaging where needed, establishes the precise diagnosis. For long-standing wear-and-tear problems, we usually try non-operative care first. For structural or acute problems, surgery may be recommended straight away. We present all options as a shared decision, ensuring you feel confident in the path forward.

What to expect

Golfer's elbow, or medial epicondylitis, is a wear-and-tear condition of the tendons on the inside of your elbow. For many people, symptoms settle with time and conservative care. In young tennis players, conservative treatment without stopping play leads to an 83% rate of spontaneous bone union. However, symptoms can persist. Elbow pain remained in 50% of subjects with medial epicondylar fragmentation at re-examination despite conservative treatment.

If your condition does not improve with rest and therapy, your surgeon may discuss procedural options. Percutaneous common flexor origin release is a safe and effective treatment that provides significant and sustainable improvements in pain and function during a 1-year follow-up period. For those with cubital tunnel syndrome, partial medial epicondylectomy results in no ulnar nerve palsy, no ulnar nerve subluxation, or medial elbow instability. Success rates for medial epicondylectomy are between 72% and 94%, as confirmed by 12 studies.

Recovery varies by individual. After partial medial epicondylectomy for cubital tunnel syndrome, 45% of patients reported mild pain at 6-month follow-up. Stiffness is rare even with postoperative immobilization of the elbow (mean of 4 weeks) following surgical treatment of displaced medial epicondyle fractures. Most patients with proximal bony UCL avulsion fractures of the pediatric medial epicondyle return to activities at about 3 months without surgery.

For professional pitchers with a history of ulnar collateral ligament reconstruction, 73.3% were able to return to sport following open reduction internal fixation of the medial epicondyle. However, only 55% returned to sport at the same level or higher. Up to half of pitchers experience medial elbow pain during the return-to-throwing period after ulnar collateral ligament reconstruction.

Your outlook depends on the specific cause of your pain. Whether managed conservatively or surgically, the goal is to restore function and reduce pain. Your surgeon will help you understand which path offers the best chance of returning to your daily activities or sport.

When to see someone

See your GP if you have persistent medial elbow pain that does not improve with rest. Ask for a specialist review if you notice weakness, instability, or a locking sensation in the joint. Seek urgent care if symptoms interfere with sleep or work, or if there is a sudden worsening of pain. Medial elbow pain can also signal ulnar nerve issues or ligament injuries. If you are a young thrower, early evaluation is important to prevent fractures.

For golfers, understanding your swing mechanics helps manage symptoms. Do not ignore pain that persists, as early treatment leads to better outcomes.

In more depth

This section goes further than you need for your own treatment decisions. Golfer's elbow is worth the extra reading because it is usually presented as the inner-elbow version of tennis elbow, and in two respects that framing misleads: what predicts it is only partly mechanical, and the presence of a second problem alongside it changes what surgery can achieve.

MOST OF IT SETTLES WITHOUT AN OPERATION

The headline figure is the reassuring one. In a review of medial elbow pain, **conservative management improves nine out of ten patients**, while surgical debridement carries a success rate of **80% to 85%** [1].

Read those two numbers together rather than separately. Non-operative care has the higher success rate. Surgery is not a better version of the same treatment – it is the option for the minority in whom time and load management have already failed, and it succeeds slightly less often than the first-line treatment does.

For the exercise component specifically, the evidence supports strength training reducing symptoms in tendinosis, with manipulation techniques offering a short-term analgesic effect that may permit more vigorous stretching and strengthening – though the authors describe the results as not yet conclusive [2].

THE RISK FACTORS ARE NOT ONLY ABOUT HOW MUCH YOU USE THE ARM

Epicondylitis is common among working-age people, and **physical load factors, smoking and obesity are strong determinants** [3]. Smoking and body weight are not what most people expect to hear about a tendon problem, and both point to the tendon's blood supply and metabolic environment rather than to how hard it is pulled.

The occupational data go further. Across **1,824** workers, statistically significant relationships were found between numerous personal and occupational psychosocial factors and both medial and lateral epicondylitis, persisting **after adjustment for demographics and job physical exposures**. The largest associations were between **physical exhaustion after work and lateral epicondylitis, at an odds ratio of 7.04**, and between **mental exhaustion after work and medial epicondylitis** [4].

That adjustment is the important part of the sentence. The association is not simply that tired people do heavier work – the relationship survived controlling for the physical exposure. It does not establish that exhaustion causes tendinopathy, but it does mean that a treatment plan built only around load, and ignoring how depleted someone is by their working day, is addressing part of the picture.

WHY THE ULNAR NERVE MATTERS TO THE OUTCOME

Medial elbow pain requires a broad differential – ulnar nerve disorders, cervical radiculopathy and ligament injury all produce pain in the same place [1]. The condition itself arises from repetitive eccentric loading and valgus overload, and is initially managed with activity modification and rehabilitation, surgery being reserved

for persistent symptoms [5]. The ulnar nerve is the one that most affects results, because it runs immediately behind the tendon origin being treated.

Where debridement is performed, its success rate **may be negatively affected by concomitant ulnar neuritis** [1]. The practical consequence is that pain persisting after a technically successful debridement is not necessarily a failed operation – it may be that the nerve, not the tendon, was generating a share of the symptoms all along. Numbness or tingling in the ring and little fingers alongside inner-elbow pain is therefore worth reporting before any operation is planned, not after.

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